# SYSTEMIC REVIEW OF THE TRAINING CENTERS

**Operated by**
**Department of Mental Health, Mental Retardation & Substance Abuse Services**

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**Office of the Inspector General**
**For Mental Health, Mental Retardation**
**And Substance Abuse Services**

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Inspector General

## Reports:

#102-04 Southside Virginia Training Center
#103-04 Southeastern Virginia Training Center
#104-04 Central Virginia Training Center
#105-04 Southwestern Virginia Training Center
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**OPERATED BY**
**DEPARTMENT OF MENTAL HEATLH, MENTAL RETARDATION & SUBSTANCE ABUSE SERVICES**

**AUGUST 19 –OCTOBER 14, 2004**

**OIG REPORT #107-04**

## EXECUTIVE SUMMARY

The Office of the Inspector General (OIG) conducted a primary inspection at each of the five training centers operated by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). The facilities and inspection dates were as follows:

Southside Virginia Training Center / August 19-20, 2004
Southeastern Virginia Training Center / September 2-3, 2004
Central Virginia Training Center / September 8-9, 2004
Southwestern Virginia Training Center / October 8-9, 2004
Northern Virginia Training Center / October 13-14, 2004

Each primary inspection involved a review of the facility through the application of thirty-two (32) quality statements organized into five (5) domains. The quality statements were identified through interviews conducted by the OIG with five different stakeholder groups. These groups included parents and advocates, the training center directors, community services board (CSB) mental retardation services directors, DMHMRSAS Central Office Facility Operations staff, and DMHMRSAS Office of Mental Retardation Services staff.

During each inspection, interviews were completed with administrative, clinical and direct care staff. Tours were conducted in selected residential areas and in on-site day treatment/training program buildings. Documentation reviews included, but were not limited to: resident records, approved behavioral plans, selected policies and procedures, staff training curriculums, and the facility quality management plan.

This report contains three sections. Section One is the systemic report. Section Two provides the recommendations regarding system-wide changes and improvements. Section Three contains each of the five individual facility reports.

## INTRODUCTION

The Code of Virginia (§§37.1-256.3) outlines the powers and duties of the Inspector General, one of which is to provide oversight and to conduct announced and unannounced inspections at the facilities operated by DMHMRSAS on an ongoing basis. Historically, the OIG has reviewed each of the facilities separately and made recommendations specific to that environment of care. One of the goals established in the FY 2004-2006 Strategic Plan for the OIG is for the OIG to conduct oversight activities that monitor the quality of services provided in the mental health, mental retardation and substance abuse service delivery system and identify needed improvements within the system. One objective outlined in support of this goal is to conduct systemic inspections of the state facilities. As four of the five training centers were scheduled for review during late summer and early fall of 2004, the decision was made to conduct a system review of all five training centers operated by DMHMRSAS.

The review focused on five key areas, which included: the facility's mission and values, access and admission services, service provision / active treatment, facility operations and community relationships. Recommendations for performance improvement that impact the entire system are contained within this report. In addition any recommendations specific to a facility are located in the individual facility report.

The OIG values the input of consumers, families, and service providers in accomplishing its mission, which is to serve as a catalyst for improving the effectiveness, efficiency and the quality of services provided by the publicly funded mental health, mental retardation and substance abuse services system. This report is, in part, a result of the willingness of others to provide counsel regarding the OIG review process and to assist this Office in continuously improving the OIG systems for inspecting, monitoring and reviewing the quality of services provided by state facilities and licensed programs.

**Development of the Review Instrument**

The OIG conducted separate interviews with five stakeholder groups that have an interest in services provided to persons with mental retardation. These groups included parents and advocates, the training center directors; community services board (CSB) mental retardation directors, DMHMRSAS Central Office Facility Operations staff, and DMHMRSAS Office of Mental Retardation Services staff.

Each group was asked the following questions:

1. What are some of the key indicators that the services provided by the training centers are: appropriate, adequate in quality, and adequate in quantity?
2. How do you assess the effectiveness of the training center?
3. What are the key indicators that the facility environment is appropriate to enable the delivery of quality care?
4. What are the elements or factors that determine the adequacy of staffing?
5. What are the indicators that the state's training centers are adequately meeting the needs of the community?

6. What are the external factors that influence (positively/negatively) the training centers' ability to do a good job?
7. What indicators enable assessment of how efficiently a training center is operating?

Thirty-two quality statements organized into five domains were developed from these responses and research conducted by the OIG. Between August 19 and October 14, 2004, a primary inspection was conducted at each of the five training centers using these quality statements as the basis for the inspections.

**Domains and Quality Statements**

Mission and Values

1. The facility has a clear mission statement.
2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.

Access and Admissions

1. Policies and Procedures that govern admission are consistent with the facility's mission statement.
2. Admission to the facility is based on a thorough assessment of each client's needs and level of functioning.
3. The facility has a mechanism in place for addressing emergency admissions.

Service Provision / Consumer Activities

1. Activities are designed to facilitate socialization, skills acquisition and community integration.
2. Residents are actively engaged.
3. Activities occur as scheduled.
4. Residents are supported in participating in off-grounds activities.
5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.

Facility Operations / Resident and Staff Safety

1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.
2. There are adequate safeguards to protect residents from abuse and neglect.
3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.
4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.
5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.
6. Medication usage is appropriately managed.
7. There are mechanisms to address areas of concern regarding staff safety.

Facility Operations / Living Environment

1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.
2. The residential environment is clean, odor free and well maintained.
3. There is evidence that the residents are being taken care of by the facility.
4. The facility provides for access to primary health care that is coordinated and comprehensive.
5. The facility has a mechanism for accountability of residents' money.

Facility Operations / Staffing Patterns

1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.
2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of resident supports and care.
3. Direct care staff possesses the competencies necessary for providing services.

Facility Operations / System Performance

1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.
2. There is a system for continuous quality improvement.
3. Consumers and other stakeholders have an active role in program development, and quality improvement activities.

Community Relationships

1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in its catchment area.
2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders.
3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.
4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.

The application of the quality statements served as the basis for completing a report regarding each facility and offered comparative information for use in the overall systemic report.

## GENERAL PROFILE OF THE FIVE TRAINING CENTERS

DMHMRSAS operates five training centers, which are located across the Commonwealth. The two oldest and largest facilities are Central Virginia Training Center (CVTC) in Lynchburg (circa 1911) and Southside Virginia Training Center (SVTC) in Petersburg (circa 1939). The three smaller training centers were all built approximately

30 years ago. They are Northern Virginia Training Center (NVTC) in Fairfax, Southeastern Virginia Training Center (SEVTC) in Chesapeake and Southwestern Virginia Training Center (SWVTC) in Hillsville.

The state-operated training centers are designed to provide residential and habilitation services for persons with mental retardation. All of the facilities are certified by the US Centers for Medicare and Medicaid Services (CMS) as intermediate care facilities for the mentally retarded (ICF/MR). Only CVTC is also certified for providing skilled nursing and acute care services.

In 1990, NVTC was investigated by the Department of Justice (DOJ) for allegations of violating the civil rights of residents under the Civil Rights for Institutionalized Persons Act (CRIPA). The settlement agreement established between the DOJ and the state resulted in the provision of additional resources for NVTC to create an environment in which residents had increased access to individualized habilitation services. This was, in part, accomplished through greater access to specialized professionals and increased staffing patterns for programming and supervision of residents. Additional funding and a reduction in the census of the facility provided the resources to enhance services. Since that time DMHMRSAS has made a concerted effort toward assuring that all residents in the state-operated training centers are provided with quality residential, habilitation and training services, which are designed to meet the individual needs of the residents.

**Operating Capacity and Census**

According to the DMHMRSAS Comprehensive State Plan (2004-2010), there has been a steady reduction in the combined average daily census at the training centers since 1976. The report indicates that the combined **average daily census** in FY1976 was 4,293 and **1,581 in FY 2003**. The decline in the census at the training centers resulted from a growth in community-based residential and training programs designed to meet the needs of those persons who could be served in a less restrictive setting. The introduction of Medicaid Mental Retardation Home and Community-Based Waiver (MR Waiver) funds, which support the provision of community-based services as an alternative to institutional care, was a major factor that enabled the census to drop steadily over the past fifteen (15) years. With the availability of Medicaid to support community-based services, individuals who would have required institutional care in the past could chose to remain in the community. This served to reduce the admissions pressure on the training centers.

Two factors determine the operating bed capacity of a facility: (1) the size, arrangement and condition of the physical plant and (2) the staffing pattern and available services which are determined by funding level and the decisions made by facility management regarding how to deploy resources. The **operating capacity** at the facilities on July 1,

2004, according to information provided by each facility **totaled 1,647**. The distribution was as follows:

| | |
|---|---|
| Northern Virginia Training Center | 192 |
| Southeastern Virginia Training Center | 200 |
| Southwestern Virginia Training Center | 223 |
| Southside Virginia Training Center | 415 |
| Central Virginia Training Center | 617 |

The total census at the facilities on July 1, 2004, by age distribution was as follows:

**TOTAL CENSUS (JULY 1,2004)***

| Census/ age | NVTC | SEVTC | SWVTC | SVTC | CVTC |
|---|---|---|---|---|---|
| *Under 21* | 0 | 6 | 3 | 3 | 8 |
| *21-30* | 21 | 54 | 37 | 16 | 18 |
| *31-40* | 64 | 60 | 46 | 77 | 87 |
| *41-50* | 56 | 50 | 60 | 159 | 200 |
| *51-60* | 35 | 21 | 44 | 79 | 161 |
| *61-70* | 9 | 6 | 23 | 24 | 71 |
| *Above 70* | 3 | 2 | 5 | 26 | 35 |
| ***TOTALS*** | **188** | **199** | **218** | **384** | **580** |

*Data provided by the facilities

Of the 1,569 residents in the training centers on July 1, 2004,

- 20 were residents under the age of 21 or 1% of the total population
- 146 were between 21-30 or 9% of the total population
- 334 were between 31-40 or 21% of the total population
- 525 were between 41-50 or 34% of the total population
- 340 were between 51-60 or 22% of the total population
- 133 were between 61-70 or 8% of the total population
- 71 were residents over the age of 70 or 5% of the total population

As the data indicates, it is unusual to have persons less than 21 years old in facilities since the Individuals with Disabilities Education Act (IDEA) has provided access to an appropriate public education for children with disabilities. Generally, younger persons are admitted when they have serious behavioral challenges or serious physical/medical conditions that cannot be accommodated in a community or home setting. According to state guidelines, children under the age of 18 cannot be admitted to a facility that does not hold the appropriate license for serving that age population. Only SWVTC and SEVTC are licensed as a residential treatment facility for children. SWVTC is licensed to accept children between the age of 13-17. SEVTC is licensed to accept children between the ages of 8-17. Children under the age of 18 who are served at CVTC are provided care and treatment in the facility's skilled care unit, which is certified by CMS. CVTC is currently serving three children, under the age of 10 in the skilled care unit. The children

have been placed in the unit due to the complexity of their medical conditions in conjunction with their mental retardation and developmental disabilities.

The data highlights that the training centers are providing services to consumers of all ages. In the 2000 article published by Special Olympics, Inc., entitled, The Health Status and Needs of Individuals with Mental Retardation, Sarah Horwitz, PhD and her colleagues in the Department of Epidemiology and Public Health at the Yale School of Medicine reported that "the average life expectancy of older adults with mental retardation is 66.1 years, but that younger adults with mild mental retardation are expected to live as long as their peers without mental retardation." The article continues by indicating that not only are persons with mild mental retardation living longer but individuals with more severe mental retardation are experiencing increased life expectancy.

The fact that individuals with mental retardation are living longer has significant implications for both facility and community services and will have to be taken into account as DMHMRSAS and the system of care plan for future services. The cost of not only residential and training services but also healthcare will grow as life expectancy increases. According to Dr. Horwitz, "these individuals are increasingly faced with the same chronic diseases as the general population, such as cardiovascular diseases and cancer."

**Length of Stay for the Residents**

Seventy percent (70%) or 1,101 persons being served by the training centers on July 1, 2004, have been residents for a period of greater than twenty years. The following chart provides a breakdown of the length of stay on that date.

**LENGTH OF STAY DATA (JULY 1, 2004)***

| Length of Stay | NVTC | SEVTC | SWVTC | SVTC | CVTC |
|---|---|---|---|---|---|
| *Less than a yr* | 2 | 4 | 9 | 7 | 2 |
| *1-5 years* | 15 | 29 | 24 | 12 | 20 |
| *6-10 years* | 18 | 20 | 30 | 23 | 22 |
| *11-15 years* | 12 | 11 | 31 | 15 | 1 |
| *16-20 years* | 21 | 46 | 42 | 14 | 38 |
| *More than 20* | 120 | 89 | 82 | 313 | 497 |
| ***TOTALS*** | **188** | **199** | **218** | **384** | **580** |

*Data provided by the facilities

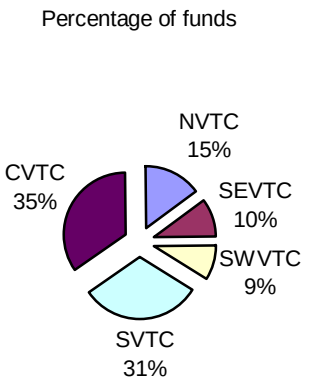
According to the direct care staff interviewed at all of the facilities, for the many residents who have lived in the facility for the majority of their lives, the facility is, for all practical purposes, the residents' home and social community. Interviews with persons that facilitate discharge planning both in the community and the facility reported that a

well coordinated process for assisting residents as they transition into the community is vital for the success of the placement. This is particularly true for those individuals who have been residents at the facility for an extended period of time. All of the facilities assist both the resident and the community by facilitating coordinated placement visits and the provision of staff training, however, this assistance is limited due to the lack of resources available.

**Budget and Cost**

According to the DMHMRSAS Comprehensive State Plan, the FY2003 funding from all sources for Virginia's publicly supported service system totaled $1.299 billion. The portion of this total allocated to state facilities was 38% or $489.4 million. **The total operating budget for all five state-operated training centers in FY2003-2004 was approximately $200 million. This is 40% of all funds allocated for facility services.**

The distribution of these funds is as follows:




Funding for DMHMRSAS, according to the 2004 Financial Report, is primarily derived from three sources - state general funds, special revenue funds and federal funds. The state general funds are provided through general tax revenues. Federal funds are derived from various grant programs. The special revenue fund consists primarily of Medicaid, the largest health insurance program in the nation [1], which is the principal source of revenue for the training centers. Approximately $185,305,000 or 92% of revenues from all the funding sources for the training centers comes from Medicaid.

[1] Kaiser Commission on Medicaid and the Uninsured Report, State Perspectives on Medicaid Long Term Care, January 2004, pg. 3

**FY 2003-2004 Total Expenditures by Funding Source**
**MENTAL RETARDATION TRAINING CENTERS***

| | *Total Expenditures* | General Funds | Special Revenue Funds | Other Special Funds | Federal Funds |
|---|---|---|---|---|---|
| **CVTC** | $71,028,516 | $5,712,348 | $65,316,170 | 0 | 0 |
| **NVTC** | $28,726,303 | $3,567,203 | $25,153,249 | 0 | $5942 |
| **SEVTC** | $19,875,344 | $3,592,948 | $16,260.483 | 560 | $21,355 |
| **SVTC** | $62,028,751** | $11,988,425 | $50,039,108 | 0 | $1220 |
| **SWVTC** | $18,350,719 | $1,674,240 | $16,660,614 | 364 | $15,501 |
| ***TOTALS*** | *$200,009,633* | *$26,535,164* | *$173,429,624* | *924* | *$44,018* |

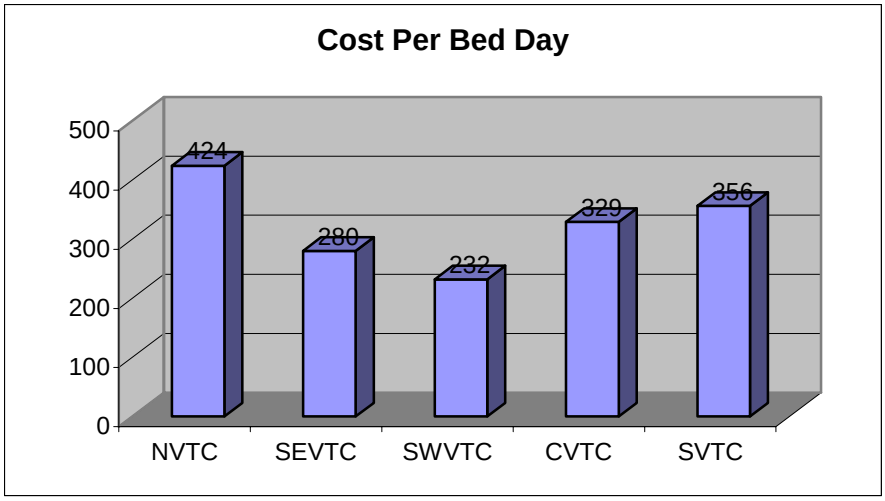
** Data compiled by DMHMRSAS Fiscal Office*
***This figure includes $12,063,351 for support services provided by SVTC to Central State Hospital, Hiram W. Davis Medical Center and the Virginia Center for Behavioral Rehabilitation.*

The cost per bed day varies significantly among the five training centers. NVTC has the highest cost per bed day at $424.26. This is 82.7% higher than the lowest per bed day cost, which is $232.12 at SWVTC.

Comparing only the three smallest training centers that have the most recently developed campuses, the variation is just as wide with NVTC at $424.26, SEVTC at $279.92 and SWVTC at $232.12.

Focusing on the two larger facilities that have the oldest buildings, the cost per bed day is $328.93 at CVTC and $414.00 at SVTC. Because SVTC's budget includes costs associated with providing extensive support services to CSH, HWDMC and VCBR, this comparison does not fairly represent the comparative costs of providing services to training center residents. After subtracting the support costs for other facilities from SVTC's budget, the cost per bed day for SVTC is $355.51 as compared to CVTC at $328.93.

The following graph depicts the differences in the costs per bed day at each of the facilities.




The **cost per bed per year** for the training centers ranges from **a low of $84,723.80 at SWVTC to the high of $154,854.90 at NVTC.**

**Capital Improvement Projects**

As outlined in the Comprehensive State Plan (2004-2010), DMHMRSAS has placed a priority on bringing "existing state facility living areas up to current life safety standards" and assuring that the environment is designed to "meet the needs of the residents currently receiving services."

The state-operated facilities are charged with the responsibility of assuring that the residential and treatment needs of residents are met in an environment that is safe and appropriate. This is very challenging as many of the training center buildings are very old, which contributes to frequent and expensive maintenance costs. Information obtained during the inspections revealed that services and supports are provided in structures that range from almost 100 years to 30 years since original construction. The populations being served have changed significantly since the buildings were constructed. As a result, the design and layout of much of the available space are not compatible with the programming that is appropriate to meet the clinical, habilitation and residential needs of the residents. Additionally, the OIG was informed that in many situations the current buildings create barriers to resolving problems with the technological infrastructure systems such as fiber optics.

The following chart outlines the capital expenditures over the past four fiscal years at each of the five training centers:

**DMHMRSAS – RECENT CAPITAL EXPENDITURES**
**MENTAL RETARDATION TRAINING CENTERS**
**FY 2001 – FY2004***

| | **FY2001** | **FY2002** | **FY2003** | **FY2004** | ***Total*** |
|---|---|---|---|---|---|
| **CVTC** | $2,391,624 | $379,807 | $346,764 | $759,652 | ***$3,877,847*** |
| **NVTC** | $2,366,070 | $479,333 | $46,927 | $318,354 | ***$3,210,684*** |
| **SEVTC** | $1,112,458 | $598,279 | $16,375 | $30,209 | ***$1,757,321*** |
| **SVTC** | $393,453 | $480,054 | $787,315 | $4,116,329 | ***$5,777,151*** |
| **SWVTC** | $1,161,623 | $364,643 | $365,337 | $106,421 | ***$1,998,024*** |
| ***TOTALS*** | ***$7,425,228*** | ***$2,302,116*** | ***$1,562,718*** | ***$5,330,965*** | ***$16,621,027*** |

***Data compiled by DMHMRSAS Fiscal Office*

Each facility was asked by the OIG to identify its three top capital improvement projects. One of the most critical of the capital improvement projects that was identified by several facilities was the need to meet the current life, health and safety codes. This was particularly true of the buildings on the older campuses. (Please refer to the individual facility reports for specific details regarding the capital improvement projects.)

DMHMRSAS has recently prepared an overview of capital improvement plans for all state operated facilities. Specific plans are identified for all five training centers. These include renovation of existing buildings, replacement of residential cottages and other buildings, additions to existing buildings, and the development of a master plan at one facility. Also included are projected costs for the complete replacement of several training center facilities. Projected costs identified in this overview for the next three biennia are as follows: FY2006-2008 $155,026,500, FY2008-2010 $287,490,000, and FY2010-2012 $224,033,000 - total projected six year cost of $658,540,517. In support of the plans described in this overview, the Department's Comprehensive State Plan indicates that DMHMRSAS is considering replacing the two large training centers with complexes designed to serve the needs of the current population of more medically acute and physically challenged residents. It also describes a need to review the needed renovation costs and the feasibility of maintaining the three smaller training centers.

In light of the fact that projected costs for renovation and replacement of training center facilities are so high, it will be critical for DMHMRSAS to undergo a comprehensive planning process that identifies clearly the anticipated target population and needed capacity of the training centers before physical plant improvements are planned and funds are requested. A recent DMHMRSAS presentation regarding facility service delivery issues indicated that the anticipated census for the training centers in 2010 would be 1,320. This projected census represents an additional drop in the statewide census of 261

individuals over approximately five years. The presentation also informed the OIG that this projection takes into account such considerations as demographics, population growth and an increase in community based programs and trends.

## MISSION AND VALUES

Christopher Bart a leading researcher in the art of mission statements says, "a good mission statement captures an organization's unique and enduring reason for being, and energizes stakeholders to pursue common goals. It also enables a focused allocation of organizational resources because it compels a firm to address some tough questions: What is our business? Why do we exist? What are we trying to accomplish?" (Bart 1998).[2]

As a part of the restructuring and reinvestment process, DMHMRSAS created a vision statement for the publicly funded mental health, mental retardation and substance abuse services system during the spring of 2004. This vision reflects a commitment to provide a system of care that values each consumer's ability to make choices to the degree possible. The recently adopted vision statement outlines that it is the vision of DMHMRSAS that there be "a community-based system of services that promotes self-determination, empowerment, recovery, resilience and the highest possible level of consumer participation in work, relationships, and all aspects of community life."

In support of this vision, it is the mission of DMHMRSAS Central Office to "provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance abuse disorders. We seek to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community for these individuals."

Given the importance of a clearly defined vision and mission for any organizational entity, especially one as complex at the Commonwealth's publicly funded system of care, the DMHMRSAS Commissioner is to be commended for his efforts to clarify direction.

Inspections of the five training centers revealed that NVTC, SWVTC and SVTC had developed formalized mission statement. SVTC incorporates their mission and values in a well-developed quality plan, which outlines the goals and objectives established by the facility to effectively accomplish its prescribed mission. At both CVTC and SEVTC there was widespread unawareness that the facility had a formalized mission statement. The new director at CVTC reported that she has established a goal of reviewing and revising the mission of the facility as a goal for this fiscal year.

The SWVTC Quality Improvement Council conducted its annual review of the facility's goals during the Summer 2004. The Quality Improvement Council used the system vision statement as the foundation for revising the facility's vision statement. The facility

[2] Bart, Christopher. (August 1998). "Mission Matters." The CPA Journal. Vol. 68 Nu8 p56-57

director emphasized the new vision statement in the employee newsletter, asking all employees to reflect on the recent changes and provide input on ways to effectively address the goals and objectives established.

The majority of staff were able to provide a working definition of key elements relevant to the mission of their specific facility, whether there was a formal mission statement or not. Staff comments included:

- The provision of high quality services with the resources available
- The protection of the residents
- The provision of treatment designed for skills development and eventual community placement
- The provision of campus-wide support services
- Address each resident's individual needs through person-centered planning
- Provide a safe environment
- To assure a well-trained competent workforce provides services

## ACCESS TO SERVICES

Interviews revealed that there are three types of admissions to the training centers. These include: regular admissions, emergency admissions and admissions for respite care services. The emergency admissions and respite care services are limited to no more than 21 consecutive days and a total of 75 days in a calendar year for an individual consumer. Admission to the training centers is regulated by the Code of Virginia (**§§**37.1-65.1and 37.1-65.2) and is procedurally outlined in the DMHMRSAS Admission and Discharge Protocols for Persons with Mental Retardation Served in State Mental Health Facilities. It is also governed by regulation 12 VAC 35 – 190 – 10 et seq and
12 VAC 35 – 200 – 10 et seq.

Persons with a diagnosis of severe (IQ 20-34) or profound retardation (IQ below 20) are given priority for admission to the facilities. The data provided to the OIG by the facilities demonstrated that the current configuration of residents at the training centers is consistent with the established priorities. The data provided by CVTC indicated that 74% of the facility's 580 residents have been assigned an unspecified diagnosis. Unspecified mental retardation is typically used when there is evidence of mental retardation but not enough information to establish a level of functioning. None of the residents of the other four centers have been assigned an unspecified diagnosis.

**Resident Classification by Mental Retardation Diagnosis (July 1, 2004)***

| | Mild (IQ 50-69) | Moderate (IQ 35-49) | Severe (IQ 20-34) | Profound (IQ < 20) | Unspecified |
|---|---|---|---|---|---|
| **CVTC** | **3** | **16** | **28** | **102** | **431** |
| **NVTC** | **4** | **24** | **22** | **138** | |
| **SEVTC** | **15** | **41** | **73** | **70** | |
| **SVTC** | **10** | **27** | **83** | **264** | |
| **SWVTC** | **6** | **21** | **47** | **144** | |
| **TOTAL** | **38** | **129** | **253** | **718** | **431** |

** Data provided by the facilities*

There are a variety of disorders associated with mental retardation, including epilepsy, cerebral palsy, vision and hearing impairments, speech/language problems, and behavior problems. [3] A study conducted in 1985 by Baird and Sadovnick indicated that the number of associated disorders appears to increase with the level of severity of mental retardation. [4] The number of residents that require the use of a wheelchair is used as one measure of impairment within the training centers. Interviews revealed that 610 or 37% of the residents at the training centers are non-ambulatory requiring specialized wheelchairs. Not only does this have implications for the treatment and physical management of the residents, but also impacts staff training and space considerations.

**Regular Admissions**

It is the responsibility of the referring community services board (CSB) to assure that the least restrictive alternatives to institutionalization are identified and considered prior to submitting an application for admission to the training center that serves the area where the individual or the individual's legally authorized representative resides. Each center has an admission review committee or team, which consists primarily of members of the facility's medical, residential and habilitation staff. The committee reviews the application and applicable assessments. The CSB completes a number of assessments prior to admission, which are used as reference points for determining whether the applicant is appropriate for admission. Community assessments conducted and submitted as a part of the admission process include, but are not limited to: the consumer's current medical status which includes immunization history, a psychological (completed within the last than 3 years), social history, current individualized educational or habilitation plan, vocational evaluation (if the consumer is in a day program) and a prescreening

[3] McLaren, J. & Bryson, S. E. (1987). Review of recent epidemiological studies in mental retardation: Prevalence, associated disorders, and etiology. American Journal of Mental Retardation, 92, 243-254.

[4] Baird, P. A. & Sadovnick, A. D. (1985). Mental retardation in over half-a-million conservative livebirths: An epidemiological study. American Journal of Mental Deficiency, 89, 323-330.

evaluation report which includes identification that no less restrictive alternative exists, training recommendations and discharge plans.

The committee's decision is communicated to the facility director, who has 30 days to notify the referring CSB of the decision. If it is determined that the applicant is not suitable for admission, the reasons for the denial of the admission are communicated in writing. CSBs have access to an appeal process if they do not agree with the decision. If accepted for admission, judicial certification of eligibility must occur. This process only certifies that the person is eligible for admission enabling the facility to accept the individual.

SWVTC has recently implemented a special program designed to address the often-challenging training and behavioral issues of the dually diagnosed (MH/MR) population. The Pathways Program, which was established in response to the needs of the community, uses person centered planning as the framework for developing goals and strategies with the residents. Person centered planning is predicated on the belief that the person needs to be a full and respected participant in any decisions that impact his/her life. Staff in this program report that persons with very challenging behaviors have been able to return to the community with increased skills in a relatively short period of time. Interviews indicated that nine individuals had been served in the program since it began a little over a year ago.

The admission process to the Pathways Program is the same as regular admissions to the facility except a regional board makes the final determination regarding admissions, not just the facility director. This collaborative admission process enables the CSBs in the region and the training center to take shared responsibility for use of the program resources and management of the census.

From the period of July 1, 2003 through June 30, 2004, there were 25 regular admissions to the training centers. On July 1, 2004, there were 43 persons on the waitlists of the five training centers for an approved admission. These included:

**Waitlist for Admission (July 1, 2004)***

| Facility | Number of Admissions Completed (July 2003-July 2004) | Number of Persons on Waitlist With an Approved Admission (July 1, 2004) |
|---|---|---|
| CVTC | 2 | 0 |
| NVTC | 1 | 34 |
| SEVTC | 5 | 3 |
| SVTC | 8 | 1 |
| SWVTC | 9 | 5 |
| Total | 25 | 43 |

**Data provided by the Facilities*

**Emergency Admissions**

The admission process for emergency admissions is similar to regular admissions. Interviews indicated that requests for emergency admissions usually occur as a result of an unexpected or imminent change in the individual's living situation or environment, which has the potential of creating a risk of physical or emotional harm. It was reported that the facilities make every effort to facilitate emergency admissions as quickly as possible if admission is deemed appropriate. Some of the factors that influence the admission include the nature of the emergency, the gender of the client, and the availability of space.

Interviews revealed that an increasing number of emergency admissions typically involve individuals with mild or moderate mental retardation who also have acute symptoms of serious mental illness. These individuals are usually referred to a state-operated psychiatric hospital for stabilization and treatment. A study in 1990 by Jacobson estimated a 40% prevalence of mental illness among persons with mental retardation through the use of psychopathology rating scales in institutional or clinic samples. The study also indicated that individuals with mental retardation appear to display the full range of psychopathology evidenced in the general population. [5] The OIG was informed by the facilities that there are 758 persons identified as dually diagnosed (MH/MR) across the entire state-operated facility system. Of that number, 622 are in the training centers. This number represents 40% of the residents in the training centers at the time of the inspections.

Satisfaction surveys conducted by the OIG with the MR directors in the CSBs outlined that one area of dissatisfaction with the services provided by the facilities is the difficulty the CSB experience when trying to secure emergency admissions for the often challenging dually-diagnosed (MH/MR) population. As the chart below indicates, there were 47 requests for emergency admissions to the training centers, and 15 were completed during the period of July 2003 - July 2004.

[5] Jacobson, J. W. (1990). Do some mental disorders occur less frequently among persons with mental retardation? American Journal of Mental Retardation, 94, 596-602.

**Emergency Admissions (July 1, 2003 – June 30, 2004)***

| Facility | Number of Emergency Admissions Requested Within the Region | Number of Emergency Admissions Completed |
|---|---|---|
| CVTC | 12 | 6 |
| NVTC | 4 | 0 |
| SEVTC | 20 | 1 |
| SVTC | 8 | 5 |
| SWVTC | 3** | 3 |
| **Total** | **47** | **15** |

**Data provided by the facilities*
***In addition to these 3 requests for emergency admission from within the region,*

SWVTC received 23 requests for admission to the Pathways program from out of the region. Given the relatively small size of the program, SWVTC has a policy of not accepting out of region referrals.

**Respite Care**
Respite care usually applies to brief stays (less than 21 consecutive days), which are designed to provide relief for the primary caregiver(s). Respite care requests often result from emergency situations such as an out-of-state serious illness or a death in a family.

There were 53 requests for respite care services from July 1, 2003 to July 1, 2004. Forty-seven of the requests were accommodated. NVTC indicated that 12 persons were served during the 29 respite visits completed during the reporting period. Two additional individuals were accepted at NVTC but chose not to use the service.

**Respite Care (July 1, 2003 – June 30, 2004)***

| Facility | Number of Requests Made for Respite Care | Number of Respite Care Requests Accommodated |
|---|---|---|
| CVTC | 0 | 0 |
| NVTC | 35 | 29 |
| SEVTC | 0 | 0 |
| SVTC | 6 | 6 |
| SWVTC | 12 | 12 |
| Total | 53 | 47 |

**Data provided by the facilities*

## SERVICE PROVISION

Five areas of quality related to service provision were examined. These focused on the design of the habilitation and training programs, the availability of these programs and

other opportunities to the residents, and the manner in which the services are utilized to assist residents as they transition effectively to the community.

Active treatment occurs when services and supports are continuous, consistent and are designed to assist the resident in acquiring the skills necessary to maintain optimal functioning, prevent skill loss and gain maximum independence. Some of the key components of a quality program of active treatment include thorough assessment, individualized plans of care and on-going review. A thorough assessment of the person's level of functioning and skill needs, including the person's strengths and preferences, is required in order to formulate an effective habilitation plan. An individualized habilitation plan is developed in order to guide the interventions that assist the person reach his or her established goals. Ongoing review assures that the goals are realistic and relevant to the person's current level of functioning. Record reviews at the five training centers revealed that all of the facilities have active treatment programs that are based on these key components. The resident records that were reviewed revealed evidence that the habilitation plans are based on the completion of a thorough assessment of the person by multiple disciplines. Interviews with training program staff and reviews of the habilitation plans indicated that all of the facilities have programs designed to facilitate socialization, skills acquisition and community integration.

All of the facilities offer day programs including vocational and prevocational training programs. Observations revealed that the programming, particularly during the day shift, was occurring as planned. Both SWVTC and SEVTC have very limited space for housing their day programming activities. This lack of programming space is a distinct disadvantage for these facilities. Evening activities were occurring at all facilities, however, there was some variation regarding the ability of the facilities to offer planned activities as scheduled. Occasional inadequacy of staffing was the primary factor that caused disruption in the consistency of programming.

Staff members were generally knowledgeable of the goals and activities for the residents in their care. Overall, staff were noted to treat the residents with dignity and respect. Most spoke with pride regarding the accomplishments of the residents. In fact, the majority of the direct care staff interviewed indicated that it is the relationships they have been able to establish with the residents that motivate them to continue their employment. Many of the staff at the facilities have been employed at their respective facilities for longer than 15 years. All of the facilities provided residents with opportunities to participate in off-grounds activities. Even though the majority of activities are recreational in nature, program staff described methods in which the outings increase the residents' awareness of their community and aides each in making connections that will assist them as they move towards increased community integration.

Social Workers within the facility, in conjunction with the community liaisons in the CSBs, assist the residents in making a smooth transition into the community through trial visits, staff contacts and other efforts designed to link them to community groups and activities. The degree to which staff at the training centers do this varies considerably among the five facilities.

## FACILITY OPERATIONS/RESIDENT AND STAFF SAFETY

The facility operations category was divided into four review areas. These included a review of the safety of the environment, the condition of the physical environment, the staffing patterns, and system performance.

**Safety of the Environment**
In all of the training centers, the OIG team was informed of a number of mechanisms utilized by the facilities for assessing the safety and security of the residential units, specifically, and the campus in general. Maintaining the safety and the security of the residents, staff, volunteers and visitors was identified most frequently as the primary responsibility of the training centers.

Inspections of the physical environment occur routinely. Work orders are completed regarding any item identified for repair or replacement. Work orders are prioritized according to the degree of risk involved, with those that pose a hazard or safety risk to either the staff or the residents completed first. Fire and emergency medical drills are routinely conducted. Interviews revealed that residents are evacuated during the drills so that the facilities have an accurate assessment of the time it would take to successfully vacate the buildings. In addition, the facilities have security officers onsite to address campus security concerns. Security personnel at both SVTC and CVTC are also sworn law enforcement officers. SVTC is the only training center with a fire department on campus.

During the inspections, the OIG was informed of the safeguards established at each of the facilities to protect the residents from abuse, neglect and critical incidents. Preservice training at the facilities includes a review of the residents' rights and the procedures for recognizing and reporting abuse and neglect. Staff at all of the training centers were observed interacting with the residents with dignity and respect. These two qualities were universally identified as the foundation for how staff are expected to relate to one another and the residents. Interviews with staff demonstrated that they were well informed regarding issues associated with protecting the residents from abuse, neglect, harm or exploitation. All the facilities have risk management programs designed to identify areas of risk and to address any concerns in a timely manner.

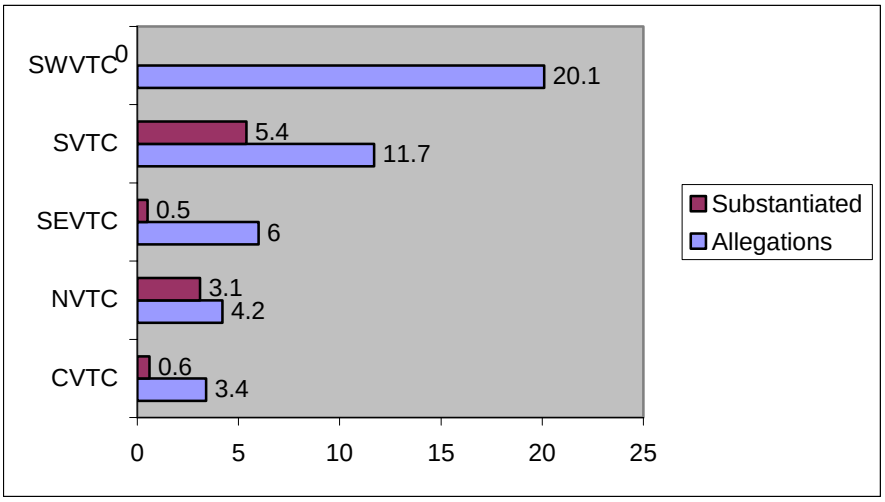
There were 129 allegations of abuse and/or neglect during the first six months of 2004 at the five training centers. Of this total, 32 allegations were substantiated.

The number of allegations and substantiated findings of abuse and neglect, as reported by the facilities, were as follows:

**Allegations & Substantiated Findings**
**Abuse & Neglect**
**January 1 to June 30, 2004**

| Facility | Allegations | Substantiated |
|---|---|---|
| CVTC | 20 | 4 |
| NVTC | 8 | 6 |
| SEVTC | 12 | 1 |
| SVTC | 45 | 21 |
| SWVTC | 44 | 0 |

**Allegations and Substantiated Findings**
**Abuse and Neglect Per 100 Residents**
**(January - June 2004)***




**Data provided by the facilities*

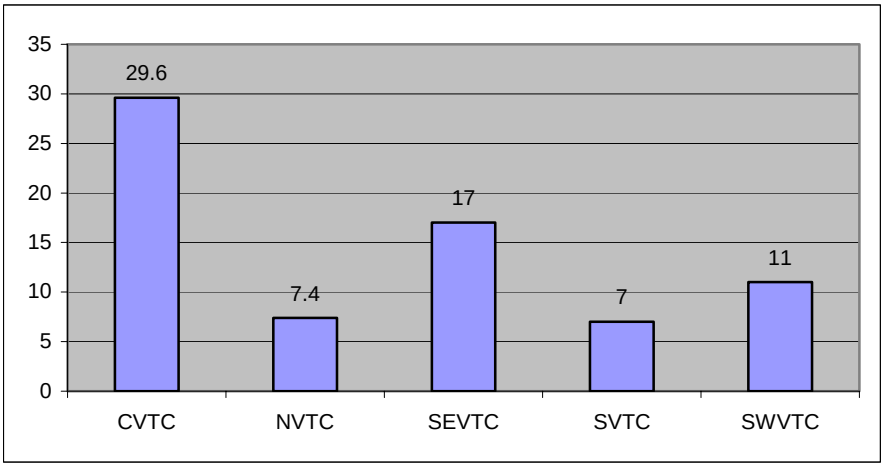
Causes of serious injuries and areas of potential risk are monitored across the centers. When areas of potential risk are identified for which corrective actions are necessary, action plans are developed and followed until the area of concern is resolved.

Documentation of critical incidents is forwarded routinely to the Virginia Office of Protection and Advocacy (VOPA) and the OIG for review and monitoring. Virginia Code § 51.5-39.12 requires the directors of the state facilities to provide written notification of a critical incident or deaths of patients/residents in the state facilities within forty-eight hours of occurrence. For reporting purposes, a critical incident is defined as an event that requires medical attention by a physician or physician extender. Reporting of critical

incidents to VOPA varies among the facilities. CVTC is the only facility that has a physician onsite at all times. Injuries that would be managed by RN staff at the other facilities routinely are referred to a physician for care at CVTC. This results in much higher reporting by CVTC than the other four centers**. During the first six months of 2004, CTVC reported 172 critical incidents, NVTC reported 14, SEVTC reported 34, SVTC reported 27, and SWVTC reported 26.**

**Number of Reported Critical Incidents Per 100 Residents***

**(January – June 2004)**




**Data provided by the facilities*

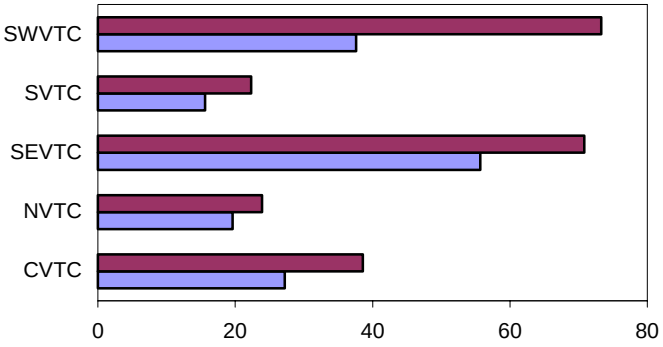
In addition, each facility tracks the number of incidents of peer-to-peer aggression. These events are reviewed both at the individual and the unit level to determine what factors may be contributing to the events. Plans are developed to decrease the likelihood of the incidents reoccurring.

Data regarding peer-to-peer aggression that resulted in injuries to one or both residents was reviewed. Injuries in these cases can range from scratches to the more serious injuries. SEVTC residents experienced 55.7 injuries per 100 residents. SVTC had both the lowest number of incidents (22.3 per 100 residents) and the lowest incidence of resulting injuries (15.6 per 100 residents). The charts below provide data related to incidents of peer-to-peer aggression and injuries that result from these incidents for the period January through June 2004.

**Incidents of Peer to Peer Aggression**
**And Resulting Injuries**
**January – June 2004**

| FACILITY | # OF INCIDENTS | # RESULTING IN INJURIES |
|---|---|---|
| CVTC | 234 | 168 |
| NVTC | 45 | 37 |
| SEVTC | 141 | 111 |
| SVTC | 86 | 60 |
| SWVTC | 160 | 82 |

**Number of Incidents of Peer-to-Peer Aggression**
**And Resulting Injuries Per 100 Residents**
**January – June 2004***



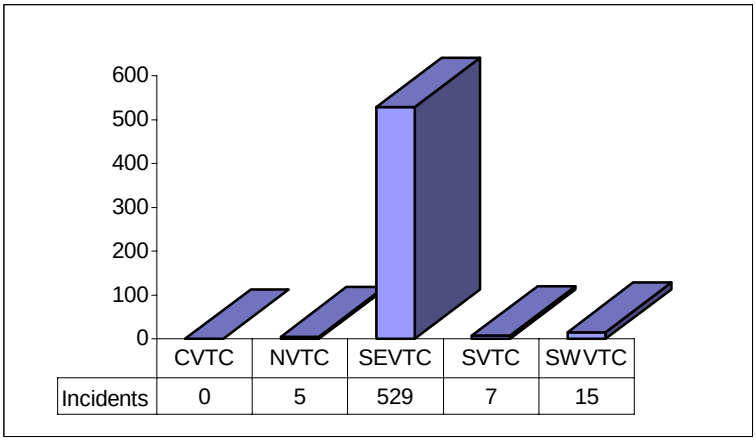

| | CVTC | NVTC | SEVTC | SVTC | SWVTC |
|---|---|---|---|---|---|
| Peer to Peer aggression | 38.6 | 23.9 | 70.8 | 22.3 | 73.3 |
| Injuries | 27.2 | 19.6 | 55.7 | 15.6 | 37.6 |

**Data provided by the facilities*

Interviews, reviews of resident records and reviews of policies and procedures demonstrated that restrictive procedures are used in accordance with policies and procedures at each of the facilities. However, there are important variations among the training centers in the use of restrictive procedures. For example, isolated time-out is a restrictive procedure that is not used at all of the facilities. Isolated timeout is defined as the removal of a resident from ongoing reinforcement to a specifically designated timeout room. CMS establishes the standards regarding the use of a time-out room in ICF/MR facilities. These standards require that a resident be under continuous visual contact for the entire timeout period. Egress may be prevented by closing the door to the room either by manually holding it closed or by using an approved hand held mechanism. CVTC is the only facility that has made a policy decision not to use isolated time-out as a restrictive procedure. As a result CVTC had zero incidents of isolated timeout during 2004. Three other facilities had very minimal use of this procedure – SVTC 7 incidents,

NVTC 5 incidents and SWVTC 15 incidents. SEVTC used this restrictive method 529 times during the same period. This is of concern to the OIG.

**INCIDENTS OF ISOLATED TIME-OUT**
**January – December 2004***




**Data provided by the facilities*

## FACILITY OPERATIONS/LIVING ENVIRONMENT

Observations revealed that overall the training centers are well maintained and provide residents with clean, comfortable and odor-free environments. Even though the facilities, in general, have a very institutional appearance, efforts at making each setting seem more homelike were noted. For example, residents have the opportunity to personalize their rooms to create a more homelike feeling. One of the residential buildings at SEVTC had numerous pieces of broken or worn furniture and other items in disrepair that made the environment less than suitable for the residents. At this facility there were other signs of lack of attention to routine maintenance and care of the facility. These included badly weathered paint on exterior wood trim on some housing units, missing ceiling tiles, and areas across the campus where grass had not recently been mowed or trimmed.

## FACILITY OPERATIONS/STAFFING PATTERNS

Workforce management has for some time been identified as one of the critical issues facing all of the state operated mental health and mental retardation facilities. It is the responsibility of DMHMRSAS to assure that each facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents/patients. Direct care staff turnover, position vacancies, and other forms of absenteeism must be maintained at a low enough level to sustain the continuity of client supports and care. Non-competitive pay structures, low wages and an ever-shrinking pool of qualified applicants contribute to the problems faced by the training centers.

There has been a concerted effort at all of the training centers to maximize the efficiency and effectiveness of their recruitment and retention strategies. Broad based job postings,

job fairs with on the spot interviewing, and the development of partnerships with local colleges to enhance staff training and development opportunities were among the recruitment strategies identified. Retention strategies involved staff recognition initiatives and open communication forums that allow for the staff to participate in decision-making and planning activities within the facility.

Direct care staff positions are often the most challenging to recruit and retain. Direct care staff provides direct personal contact with and supervision of the residents. These front-line workers have the most day-to-day contact with the persons served through personal care activities, training programs and general supervision. Staff turnover diminishes the quality of care provided by causing interruption in the resident's habilitation and progress.

Interviews with staff on all levels, but particularly with the direct care staff, indicated that they stay in their positions because they have a commitment to the individuals they support due to the positive relationships they are able to develop. Organizational factors for staff retention include feeling valued for the work accomplished, sharing the facility's goals and values, and having opportunities to learn and grow as a person and as a professional.

When asked why employees tend to leave their positions, the staff who were interviewed shared the following factors: the very nature of the work on a daily basis that leads to "burn-out" and increased job dissatisfaction and their inability to balance the demands of their personal lives with the demands of their jobs. Excessive overtime and holdovers, unreasonable amounts of paperwork and the day-to-day challenge of completing all the tasks required were described as too burdensome.

The total number of positions available at each facility and the actual number of positions include administrative, clinical and direct care positions on July 1, 2004 are listed below.

**FACILITY STAFFING – July 1, 2004**

| | NVTC | SEVTC | SWVTC | CVTC | SVTC |
|---|---|---|---|---|---|
| Census | 188 | 199 | 218 | 580 | 384 |
| Maximum Employee Levels (MEL) | 517.5 | 427 | 466 | 1584 | 1486 |
| Number of position filled | 489.75 | 421 | 445.5 | 1516 | 1374 |
| Percentage of (MEL) filled | 94.6% | 98.6% | 95.6% | 95.7% | 92.5% |

Direct Care Workers

A majority of the direct care staff interviewed (49 of 54) indicated that the biggest factor for them in determining whether or not to leave their positions is inadequate compensation. Many reported that they had to maintain two jobs in order to meet their financial obligations. This was particularly stressed at SEVTC and NVTC. Wages were identified as low in both absolute terms and as relative to the demands of the job when compared to wages outside the field and wages in other human services settings. Even though there were minor variations, the average salary for the last five hires for direct care workers in the training centers was approximately $19,000. The established minimum ratio for direct care workers among all the facilities is 1:4 for both 1st and 2nd shifts and 1:8 for the 3rd shift. Staffing patterns are adjusted from the minimums depending on other factors, such as presenting medical and behavioral concerns.

NVTC and CVTC have 1.58 and 1.56 direct care workers per resident respectively. This level of staffing is considerably higher than at the other three centers - SEVTC (1.16), SWVTC (1.07) and SVTC (1.19). The percentage of direct care positions that were vacant at the five facilities ranged from a low of 2.24% at SWVTC to a high of 9.96% at SEVTC.

**DIRECT CARE STAFFING – As of the date of each facility's inspection***

| | NVTC | SEVTC | SWVTC | CVTC | SVTC |
|---|---|---|---|---|---|
| Census on July 1, 2004 | 188 | 199 | 218 | 580 | 384 |
| Number of direct care positions | 296.5 | 231 | 233 | 692 | 598 |
| Number of position vacancies | 17 | 23 | 5 | 22 | 32 |
| Percentage of direct care positions vacant | 5.73% | 9.96% | 2.14% | 3.18% | 5.35% |
| Number of direct care staff per residents | 1.58 | 1.16 | 1.07 | 1.19 | 1.56 |

**Position vacancy numbers may be different from the Facility Staffing information on the previous page due to the varying inspection dates.*

As outlined in the DMHMRSAS Comprehensive State Plan (2004-2010), the most serious staff shortages exist at four of the five training centers: CVTC, SVTC, SEVTC and SWVTC. To address this issue, the report indicates that DMHMRSAS plans to pursue the goal of assuring "that state mental health and mental retardation facilities provide quality assessments, treatment, rehabilitation, training and habilitation services that are appropriate to the needs of the individual patients and residents. The identified objective for accomplishing this goal, according to the same report, is to bring all the state mental health and mental retardation facilities up to and maintain the active treatment and staffing levels provided in the Department's settlement agreements with the DOJ under CRIPA. For the training centers, this means adjusting staffing levels at

CVTC, SEVTC, SVTC, and SWVTC to bring them closer to the levels established at NVTC at the time that the settlement agreement was finalized. The report states that among the specific staff issues to be addressed is the securing of adequate numbers of psychologists, rehabilitation staff, primary care physicians, nurses, and direct care staff.

Each facility provided the OIG with the total number of approved positions and the number of positions currently filled for the following classifications: psychologists, psychology assistants, speech therapists, occupational therapists, physical therapists, recreational therapists, social workers, primary care physicians, nurse practitioners, psychiatrists, registered nurses, licensed practical nurses, certified nursing assistants and direct care workers. The numbers of approved positions for clinical and rehabilitation staffs were compared to the ratios established in the settlement agreement with NVTC for each of the positions based on the census of the facility as of July 1, 2004. This provides a basis for reviewing staffing patterns. The census as of a given date was selected as the basis for the calculation because some facilities operate significantly below their defined operating capacity while others do not.

Clinical and Rehabilitation Staffing Ratios

The ratios established in the settlement agreement with NVTC have been identified in the following chart along with the current ratios at each of the facilities for each position. The ratios identified were determined using the number of approved positions, not the number of positions filled as of July 1, 2004.

SEVTC fails to meet the DOJ staffing ratio standard for all seven classes of clinical and rehabilitation professionals. Three of the facilities meet or exceed the DOJ ratio standard for only one of the seven professional classes: CVTC – psychology assistant, SVTC – speech therapist, and SWVTC – occupational therapist. NVTC meets the DOJ standard for one class and exceeds the standard for five classes of professional positions. The OIG was informed that additional funding and lowering the census enabled the richer staffing ratios at NVTC.

**Clinical and Rehabilitation Staffing Ratios**

| *Positions* | *Ratios established With DOJ Ratios* | *Current CVTC Ratios* | *Current NVTC Ratios* | *Current SEVTC Ratios* | *Current SVTC Ratios* | *Current SWVTC Ratios* |
|---|---|---|---|---|---|---|
| **Psychologists (PhD and/or Masters)** | 1:34 | 1:45 | 1:31 | 1:50 | 1:38 | 1:55 |
| **Psychology Assistants** | 1:34 | 1:290 | 1:31 | None | 1:64 | 1:73 |
| **Occupational Therapists, including certified assistants** | 1:29 | 1:36 | 1:29 | 1:57 | 1:32 | 1:109 |
| **Physical Therapists, Including licensed assistants** | 1:34 | 1:48 | 1:31 | 1:66 | 1:48 | 1:73 |
| **Speech Therapists** | 1:40 | 1:83 | 1:38 | 1:50 | 1:128 | 1:73 |
| **Recreational Therapists** | 1:29 | 1:580 | 1:27 | 1:33 | 1:64 | 1:55 |
| **Social Workers** | 1:34 | 1:39 | 1:29 | 1:40 | 1:43 | 1:44 |

The following provides additional staffing information regarding the configuration of clinical and rehabilitation staffing patterns at the training centers at the time of the inspections:

*Psychologists:* Psychologists within the training centers provide psychological services to an established caseload of residents which includes, but is not limited to: the designing and monitoring of behavioral treatment programs, conducting psychological testing and evaluations and participating on the interdisciplinary teams.

- CVTC has 13 psychologist positions. Eleven masters' level positions were filled with 1 additional vacancy identified. The facility has a funded doctoral level position, but it was vacant at the time of the inspection. There are also 2 psychology assistant positions available of which one was vacant.
- NVTC has 6 psychologist positions. The current staffing includes 3 doctoral level and 2 master's level persons. The vacant position at NVTC is a doctoral level position. In addition, NVTC had 5.4 of 6 psychology assistant positions filled and 5 psychology interns working with the psychologists.

- Of the 4 psychologists at SEVTC, 1 is doctoral level and 3 are master's level positions. The facility does not have any psychology assistants. All positions were filled.
- SWVTC has 1 doctoral level psychologist and 3 masters' level psychologists at the facility. There are also 3 psychology assistants. All positions were filled.
- SVTC has 10 funded positions. Eight of the 9 master's level positions are filled. The doctoral level position is vacant. The facility also has 6 psychology assistants.

*Occupational Therapists:* Occupational therapists (OT) complete assessments to determine an individual's skill set at the time of admission and develop programs designed to enable the person to gain new skills through a variety of treatment activities. They also are instrumental in developing adaptive equipment that will offset identified resident deficits.

- CVTC has 6 occupational therapists, 10 certified occupational therapy assistants and 1 aide position dedicated to OT services.
- NVTC has 6 of the 6.5 occupational therapist positions filled, no certified occupational therapy assistant positions and 3.5 of 4 OT aide positions filled.
- SEVTC has 3.5 occupational therapists positions, no certified occupational therapy assistants and 1 OT aide position. All were filled.
- SVTC has 7 of its 8 occupational therapists positions filled. In addition, there were four certified occupational therapy assistants and 6 aide positions, all of which were filled.
- SWVTC has 1 occupational therapist and one certified occupational therapy assistant. The facility did not have any aides designated to occupational therapy services.

*Physical Therapists:* Physical therapists are vital in the development of physical management plans for each resident. These plans are in part designed to address the mobility and physical positioning of the residents.

- CVTC has 5 physical therapists, 7 licensed physical therapist assistants and 5 designated aide positions.
- NVTC has 3 physical therapists, 3 licensed physical therapist assistants and 3.5 of the 4 aide positions filled.
- SEVTC has 1 physical therapist, 2 licensed physical therapist assistants and 1 designated aide.
- SVTC has 3 of the 4 physical therapists positions filled, 4 licensed physical therapist assistants and 4 designated aides.
- SWVTC has 1 physical therapist. Two licensed physical therapist assistant positions of which 1 was vacant. The facility does not have any aide positions designated to physical therapy services.

*Speech Therapists:* Speech therapists complete diagnostic assessments and work closely with other disciplines to assure that each resident receives maximum benefit from a person-centered communications program that enhances the person's ability to relate to others.

- CVTC has 7 speech therapists.
- NVTC has 4.6 of 5 positions filled.
- SEVTC has 4 speech therapists.
- SVTC has 3 speech therapy positions, but only 1 was filled. The facility has 2 designated speech therapy services aide positions.
- SWVTC has 3 speech therapists.

*Recreational Therapists:* Recreation therapists assist the residents in developing and maintaining recreational and leisure interests and preferences through a wide range of activities, outings and programs.

- CVTC has 1 recreational therapist and 7 aides designated to recreational therapy services.
- NVTC has 6 of its 7 recreational therapy positions filled. The facility does not have any designated aide positions for recreational services.
- SEVTC has 5 of its 6 recreational therapists positions filled and a half-time aide position.
- SVTC has 6 recreational therapy positions and one designated aide position.
- SWVTC has 4 recreational therapists. The facility does not have any designated aide positions for recreational services.

*Social Workers:* Social Workers assist the residents in maintaining contact with and developing their natural support systems. Social Workers are key players in both the admissions and discharge processes.

- CVTC has 15 approved social work positions. All were filled.
- NVTC has 6.5 positions. There was 1 vacancy.
- SEVTC has 5 positions and 4 were filled.
- SVTC has 9 positions and all were filled.
- SWVTC has 5 positions and all were filled.

**Medical Staff**

The DOJ review highlighted the importance of timely access to medical care for all those served in the state-operated facilities. As previously indicated, the primary profile of the residents at the training centers consists of persons with the most severe impairments that are complicated by complex medical and behavioral needs. Appropriate and timely access to medical personnel is the first step in not only assuring that each resident's primary care needs are properly identified and treated but also that preventive health strategies are implemented.

The ratio established by through the settlement agreement with the DOJ for primary care physician coverage is 1:67 and for a consulting psychiatrist coverage is 1:400. The chart below identifies the number of medical personnel within each setting.

**Medical Staffing**
**July 1, 2004**

| | ***Primary Care Physicians*** | ***Ratio With DOJ*** | ***Facility Ratios*** | ***Psychiatric Consultation*** | ***Ratio With DOJ*** | ***Facility Ratios*** |
|---|---|---|---|---|---|---|
| **CVTC** | **9*** | 1:67 | **1:64** | **1.25** | 1:400 | **1:464** |
| **NVTC** | **3** | 1:67 | **1:63** | **0.75** | 1:400 | **1:251** |
| **SEVTC** | **2*** | 1:67 | **1:100** | **.3** | 1:400 | **1:663** |
| **SVTC** | **4** | 1:67 | **1:96** | **0** | 1:400 | **0** |
| **SWVTC** | **1*** | 1:67 | **1:218** | **1** | 1:400 | **1:218** |

** This data does not include nurse practitioners. CVTC, SEVTC and SWVTC have 1 NP each.*

Only CVTC has physicians on grounds at all times. All of the other facilities have physicians on-call after normal business hours. Staff interviewed reported an excellent response time, usually less than five minutes, when consultation with the on-call physician is necessary. Staff has been appropriately trained to handle emergency situations and are authorized to notify the appropriate authorities, such as fire and rescue, when situations dictate that this action is necessary.

The nation-wide nursing shortage has been an issue at all of the facilities operated by the Commonwealth, including the training centers. Several of the training centers have chosen to shift a traditional nursing function, such as medication administration, to specifically trained direct care workers. This allows the limited nursing staff to have increased time to conduct healthcare assessments, address emergencies, coordinate primary care and manage the day-to-day health care needs of the residents through on-going contact with both the residents and the staff that supports them.

**Facility Staffing Summary**
The staffing patterns vary greatly among the five training centers. The highest ratio of direct care workers to residents (NVTC - 1.58) is 47.7% higher than the lowest ratio (SWVTC -1.07). One training center, NVTC, meets or exceeds the DOJ staffing ratio standards for six of seven professional position classes while three training centers meet the DOJ standard for only one of these classes and one training center does not meet the

standard for any of the seven classes. The ratio of primary care physicians to residents ranges from 1 physician/63 residents at NVTC to 1 physician/218 residents at SWVTC.

It has been eight years since the NVTC DOJ settlement agreement was established. During this time the following developments have changed the facilities fairly significantly:

- The Mental Retardation Medicaid Waiver has enabled community care for more seriously disabled consumers who would have required long-term facility care in the past.
- The census of facilities has decreased.
- A higher percentage of the residents served in the facilities are medically and behaviorally challenged.
- Service models in the training centers have been modified and enhanced to meet the needs of the current population.

In light of these many developments over the past decade, it will be important for DMHMRSAS to examine what staffing levels are appropriate for the training centers in the future.

## FACILITY OPERATIONS/SYSTEM PERFORMANCE

Data collection is central to both quality assurance and risk management at the facilities. Both functions review critical indicators regarding the safety and treatment needs of the residents. This information, more importantly, is routinely used to develop performance improvement initiatives.

There was evidence at all five facilities that data collection and management have resulted in performance enhancement. One example is the development of a program that allows for electronic documentation of habilitation plans. This program provides for increased consistency in plan development and decreased time needed by staff in completing paperwork.

Until recently, each facility maintained its own system for managing information. Each facility has used the collection and management of data to enhance the service it provides, as well as to increase efficiency. However, the OIG was informed that there was little if any cross-pollination of ideas from one setting to the next resulting in the various facilities creating and re-creating similar programs.

In 2003, the Virginia General Assembly authorized the creation of the Virginia Information and Technology Agency (VITA). This agency was designed to provide an integrated system for the management of equipment and data in state government in order to enhance the effectiveness and efficiency of information technology. DMHMRSAS completed its transition to this system in October 2004.

## COMMUNITY RELATIONSHIPS

Historically, contact between the facilities and community providers has occurred during admissions, discharges and outreach activities. The restructuring and reinvestment process initiated by Commissioner Reinhard has provided multiple opportunities for facility directors and other staff to participate in regional planning meetings with community providers and other stakeholders to identify service needs and other issues relevant to the provision of service and supports to eligible citizens.

Understanding and reacting to information regarding the quality of the services provided is one of the primary functions of a well-defined quality assurance program. It is important to understand how consumers and their families perceive the services being provided in order to enhance performance. The OIG asked administrative staff to outline the strategies used by each facility for developing and maintaining working relationships with other agencies and providers in their catchment area, as well as identifying the steps they have taken to understand external stakeholder satisfaction with services. All of the facilities are involved in a number of informal and formal meetings and other events designed to develop and maintain working relationships with community partners. These collaborative sessions also provide the opportunity to seek feedback on satisfaction. No formal systems are used by the facilities to collect satisfaction information from CSBs. The facilities report very limited feedback is received from DMHMRSAS Central Office regarding the overall performance and quality of services provided by the facilities.

Consumer satisfaction assessment is an important means of measuring the effectiveness of any service delivery system. Since 2000, DMHMRSAS has used family satisfaction with services and supports as a performance measure. Surveys were conducted by Central Office with family members receiving active case management provided by the CSBs and behavioral heath authorities. While the surveys have provided valuable information, they were not designed to provide information specific to the care and treatment received in the institutions. The OIG was informed that most of the facilities did not conduct their own surveys in 2003 and 2004 because it was understood that the one conducted by the Central Office would address the facilities as well. All of the facilities, except SEVTC, have conducted formalized family/consumer satisfaction surveys in years past. Even though SEVTC has not created a formalized mechanism for determining consumer/family satisfaction, the facility, like the others, has an active parents organization that readily offers suggestions and comments regarding the quality of care. None of the facilities identified having consumers and other stakeholders share an active role in program development and quality improvement activities.

## DISCHARGES

According to the DMHMRSAS Comprehensive State Plan (2004-2010), there were 173 persons residing in the training centers that were ready for discharge and had indicated a choice to transition their training and habilitation services to the community instead of remaining in the facility. Data provided by the facilities at the time of the inspections revealed that there were 268 persons ready for discharge.

Information provided by the facilities when asked to provide the actual number of persons discharged and the number of persons clinically determined to be ready for discharge are as follows:

**FACILITY DISCHARGE DATA**

| | CVTC | NVTC | SEVTC | SVTC | SWVTC |
|---|---|---|---|---|---|
| *Number of discharges* | | | | | |
| FY 2001 | 12 | 5 | 12 | 14 | 12 |
| FY 2002 | 14 | 5 | 17 | 19 | 26 |
| FY 2003 | 7 | 4 | 8 | 20 | 10 |
| FY 2004 | 3 | 5 | 3 | 14 | 15 |
| ***Totals*** | **36** | **19** | **40** | **67** | **63** |
| | *Number of residents ready for discharge* | | | | |
| **FY 2004** | **85** | **13** | **7** | **155** | **8** |
| | *Census* | | | | |
| **FY 1990** | **1,357** | **283** | **204** | **668** | **224** |
| **FY 2004** | **575** | **185** | **198** | **392** | **215** |
| ***Differences*** | **772** | **98** | **6** | **276** | **9** |

The FY2003 state budget provided funding for 150 Mental Retardation Medicaid Waiver slots, 30 of which were targeted for use by the facilities. These slots facilitated the discharge of persons with mental retardation from both the training centers and the psychiatric facilities into the community. The slots that were designated for facility discharges were managed centrally by the DMHMRSAS Mental Retardation Office and were assigned to individuals as requested by the CSBs. The FY2004 state budget provided funding for 175 waiver slots. None were designated specifically for state facility discharge.

The 2004 Virginia General Assembly approved the funding for 860 Waiver slots. Seven hundred were designated for the community and 160 slots were designated for training center discharges. The biennial cost of these facility slots is $6.7 million in general funds. The facility slots have been assigned to the five training center as follows:

| | |
|---|---|
| CVTC | 65 |
| NVTC | 8 |
| SEVTC | 8 |
| SVTC | 62 |
| SWVTC | 17 |

Decisions regarding which residents receive the 160 Waiver slots will be made jointly by the facilities and the case managing CSB's.

Since the inception of the Mental Retardation Medicaid Waiver program, the vast majority of the slots created either by the conversion of state funds to Medicaid or by the provision of new state funding have been used to provide needed services to community consumers. As a result many individuals who would have been in need of state facility care have been able to remain in the community. This strategy of addressing urgent community need with Medicaid Waiver slots before focusing on facility discharges has worked successfully to take considerable pressure off of the "front door" of the training centers by lowering the number of applications for admissions. As the state works to enable more residents who are discharge ready to be discharged, the specific designation of Waiver slots by the General Assembly to facilities will be very important.

## SYSTEMIC RECOMMENDATIONS

**1. It is recommended that each training center review it's mission statement and make any needed changes to assure consistency with the system-wide vision statement adopted recently by DMHMRSAS. Once this is done, each facility should review its strategic objectives and initiatives to assure that these are consistent with the system vision statement and revised facility mission statement.**

**2. It is recommended that each facility develop a clearly stated set of values or principles that are consistent with the system vision statement. The purpose of these values or principles will be to guide how services are delivered to residents and how the facility will relate to the broader system of care. Once these statements are established, each facility should take the necessary steps to assure that the actions of staff at all levels and the culture of the facility reflect the value or principle statements.**

**Refer to section entitled Mission and Values on pages 12 through 13 of Report #107-04 for background on recommendations 1 and 2.**

***DMHMRSAS Response:*** *Because of the inter-relatedness of these two recommendations, DMHMRSAS responses to OIG recommendations 1 and 2 are combined. The Assistant Commissioner for Facility Management will assure that each MR facility has received copies of the Department's mission, vision, and values statements. Each training center will review their vision and mission statements for consistency with those of the DMHMRSAS. A meeting will be called with the training center Directors and other representatives to review each MR facility's mission statements, strategic objectives and initiatives, guiding values and principles, and staff training methods. The goals of this initiative are threefold:*

1.) *to ensure that facility mission statements are consistent with the system's vision and mission statements;*
2.) *to ensure the facility has a clearly stated set of values and principles that are consistent with the system vision and that will guide both service delivery to consumers and facility relationships with external partners in the service system;*
3.) *and to identify actions necessary to assure that each facility's culture and staff behaviors reflect those values and principles*

*Target completion date for this initiative is June 30, 2005.*

3. **It is recommended that DMHMRSAS establish a statewide policy that clarifies the role of the training centers in providing emergency services to consumers with mental retardation who demonstrate severe behavior management problems and consumers who are dually diagnosed with mental retardation and**

**mental illness. This policy should state clearly what conditions are appropriate for emergency admission, which are not and when it is appropriate for an individual with either of these conditions to be admitted to a state mental health hospital.**

**Refer to section entitled Access on pages 14 through 18 of Report #107-04 for background on recommendation 3.**

***DMHMRSAS Response:*** *The Department has initiated a comprehensive effort within the regions (Regional Partnerships) to develop strategic directions and an integrated strategic plan for both MH and MR services. For MR, the Regional Partnerships will address: a.) changes in utilization of training center and community ICF/MR beds; and the community services and supports that must be created or expanded to meet need by the end of each of the next three biennia (FY 06-08, FY 08-10, and FY10-12). Each region will consider required state facility capital infrastructure costs in deciding the specific types, amounts, and location of services as well as current healthcare markets and projected population and demographic changes. The MR Special Populations Workgroup has been charged with developing a methodology to assist each Regional Partnership as it examines future need for ICF/MR beds and other MR services needed. Clarification of the role of state training centers and the populations that they will serve will be an important part of the Regional Partnership discussions and planning.*

*Addressing the needs of consumers with mental retardation who demonstrate severe behavior management problems and those who are dually diagnosed with mental retardation and mental illness (MR/MI) has been a concern of the Department. At the regional level, training center staff, psychiatric facility staff, and Community Service Board (CSB) staff have been engaged in a collaborative effort to determine the most appropriate services and placement for this population. This is done both on a case-by-case basis as well as on a regional planning level.*

*The Division of Facility Management, in collaboration with the Office of Mental Retardation, and the Regional Partnership representatives will review recommendations made by the MR Special Populations Work Group and work with the Facility Directors and CSBs to examine regional need for, and access to, facility emergency services by this population and others. This will include identification of barriers to access as well as outcomes of requests during FY 2004 and the first half of FY 05; and will include development of action steps as indicated. Target date for completion is May 30, 2005.*

*The State Board for DMHMRSAS has promulgated two policies pertaining to services to consumers with dual diagnosis: Policy 1015(SYS) 86-22, Facility and Community Services Board Services to Persons who have Co-occurring Mental illness, Mental Retardation, and/or Substance Abuse (MICA, Mentally Ill Chemical Abusers, SA/MH, MH/MR, SA/MR or MH/MR/SA); and Policy*

*1017(SYS)86-31, Facility and Community Services Board Services to Persons with Mental Retardation and Mental Illness). Copies of these policies are attached for OIG review. These policies were last updated in 1993 and 1992, respectively.*

*State Board Policy 1015 posits the responsibilities of State facilities and CSBs "for ensuring, within available resources, that persons who have co-occurring mental illness, mental retardation and/or substance abuse disorders receive the services they require and to charge the Department with policy implementation" (page2). This policy emphases the provision of appropriate, comprehensive assessments, pre-screening and services throughout the system of care; provision of integrated, coordinated care that meets individual needs; and encourages development of programs for persons with multiple impairments.*

*State Board Policy 1017 posits facility and CSB responsibility specifically to ensure that individuals with mental retardation and mental illness receive necessary services. This policy states:*
*"… If pre-screening and evaluation indicate that a mentally retarded individual requires inpatient hospitalization for acute stabilization of a mental disorder which cannot be provided in any less restrictive setting, such inpatient hospitalization is provided by the State hospital system. … Training Centers will be responsible for coordinating services for the less intensive mental health needs of their residents with mental illness if their disorder does not require inpatient psychiatric hospitalization" (page 2).*

*These policies are due to be reviewed and updated. Revisions to reflect more person-centered language and to better address current practices are indicated. Because of recent turnover from new appointments, the State Board has not been able to address review as yet. To facilitate a timely update, a collaborative review of these policies first will be conducted internally by the DMHMRSAS program Offices (Mental Health, Mental Retardation, Substance Abuse Services), Operations/QA, and Planning and Development as well as by the MH and MR Facility Directors, or designees. The Associate Commissioner for Facility Management will convene and coordinate this review. Recommendations for revisions will be developed and forwarded to the State Board by September 1, 2005.*

4. **It is recommended that DMHMRSAS conduct a study to determine the appropriate staffing ratio for direct care workers and professional clinical and rehabilitation positions in the training centers before efforts are made to significantly alter staffing patterns. This study should take into account the changes in population served and census that have occurred in the facilities over the past decade since the Department of Justice (DOJ) settlement agreement with NVTC was established.**

**Refer to sections entitled Staffing Patterns, Medical Staffing and Facility Staffing Summary on pages 24 through 32 of Report #107-04 for background on recommendation 4.**

***DMHMRSAS Response:*** *The Department has been monitoring staffing needs of all training centers during formulation of the NVTC/Department of Justice (DOJ) settlement agreement as well as on an on-going basis since that Agreement. Unlike NVTC, the other Training Centers did not receive sufficient funding to meet the staffing ratios in the agreement. DMHMRSAS annually has submitted a request to the Department of Planning and Budget and /or the General Assembly for funding positions for direct care workers, professional clinical staff and rehabilitation staff. In making these requests, comparisons were made between current staffing levels and those established in the NVTC/DOJ settlement agreement. Exploration of national staffing models for state training centers has been conducted. However, no standard ratios were found; and the NVTC/DOJ ratios were adopted.*

*To more fully address staffing needs at the training centers, the DMHMRSAS has been collaborating with the facilities as well as our Office of Human Resource Development. Two current initiatives focus on Relief Factor and patient acuity. Examination is underway of the amount of Relief Factor needed to ensure appropriate coverage for direct care services. Relief factor is a numerical value used to calculate the number of persons needed to cover a position 24 hours, seven days a week. Determination of the relief factor involves calculation of many variables that impact coverage (e.g., all types of leave, training time, workman's compensation, among others).*

*A related initiative is examination of standardized, validated methods for determining consumer acuity of needs, which is a fundamental indicator for determining staffing levels. At this time, the Department is examining adoption of the Supports Intensity Scale (SIS), which is an assessment tool developed exclusively to help identify and measure the support needs of adults with mental retardation. The SIS was developed by, and is available through, the American Association on Mental Retardation (AAMR). Staff training by AAMR recommended trainers would be necessary to ensure reliability. The data gleaned would provide an indication of consumer clinical acuity that then could be used to determine staffing needs at each facility relative to population change.*

*The target completion date for these initiatives is August 2005.*

5. **It is recommended that SEVTC take immediate steps to drastically decrease or eliminate the use of isolated time-out. It is further recommended that DMHMRSAS conduct a study to determine whether or not the use of isolated time-out can be discontinued in all training centers.**

**Refer to section entitled Safety of the Environment on pages 20 through 24 of Report #107-04 for background on recommendation 5.**

***DMHMRSAS Response:*** *The DMHMRSAS has over the past several years been committed to the successful reduction of seclusion and restraint. Relative to the findings related to the SEVTC, the Assistant Commissioner for Facility Management will convene a meeting with representatives of the Office of Facility Operations/ QA, the Office of Health and Quality Care, the Office of Risk and Liability Affairs, and MR Facility Directors and their representatives to examine best practice alternatives to the use of isolated time out and undertake an analysis of alternatives used in other facilities. A series of recommendations to the MR centers will result. Target completion date is October 2005.*

*Please also refer to response for report # 103-04 specific to findings at SEVTC.*

6. **It is recommended that DMHMRSAS take steps to enable more consistent reporting of critical incidents so that the variable staffing pattern for medical personnel among the five training center no longer causes inconsistent reporting.**

**Refer to section entitled Safety of the Environment on pages 20 through 24 of Report** #107-04 for background on recommendation 6.

***DMHMRSAS Response:*** *The Director of the Office of Risk and Liability Affairs and the Director of Facility Operations will be meeting in March 2005 with Risk Managers from all state facilities to examine this recommendation. The Code of Virginia related to reporting of critical incidents (Section 51.5-39.12) requires the reporting to the Virginia Office of Protection and Advocacy (VOPA) of a critical incident defined as death or a serious bodily injury requiring medical treatment. Agreement with VOPA has defined medical treatment to be that treatment provide by a physician or an extender.*

*One of the MR Training Centers, CVTC, as indicated in the OIG report, continues to be an outlier in physician handling of critical incidents. CVTC is the only MR facility, which is a certified as a skilled nursing facility thus having physician capability around the clock to handle such cases. Thus, they do not have to maintain prn or standing orders. The Department will be re-visiting once again the reporting requirements and operational definitions of " serious bodily injury" and "medical treatment". CVTC will also be examining internal policies and practices regarding critical incident reporting as part of its participation with the above referenced group with the intent of altering policy. Final recommendations and actions will be forthcoming by August 1,2005.*

7. **It is recommended that DMHMRSAS continue to advocate for an increase in the number of Mental Retardation Medicaid Waiver slots that are dedicated to training center discharges in order to enable residents who have been**

**determined clinically ready for discharge and who wish to live in the community to be discharged. It is further recommended that DMHMRSAS continue to advocate for additional Mental Retardation Medicaid Waiver slots for the community in order to address community need and to prevent unnecessary admissions to the training centers.**

**Refer to section entitled Discharges on pages 33 through 35 of Report #107-04 for background on recommendation 7.**

***DMHMRSAS Response:*** *As the Inspector General's report has noted, DMHMRSAS is committed to promoting choice and the highest possible level of participation in work, relationships, and all aspects of community living for consumers. The Department has vigorously advocated, and will continue to advocate, for additional Medicaid Waiver slots dedicated to training center consumers who are determined clinically ready for discharge and who wish to live in the community, and for additional slots for communities to address community need and to prevent unnecessary admissions to the training centers.*

8. **It is recommended that DMHMRSAS conduct specific system-wide comprehensive planning that will clarify the population to be served, the types of services to be delivered, the projected census, and the type of physical plants needed for the training center system in the future before decisions regarding significant capital improvement projects are made. This planning process should include broad stakeholder involvement.**

   **Refer to section entitled Facility Infrastructure and Capital Improvement Projects on pages 11 through 13 of Report #107-04 and see individual facility reports for background on recommendation 8.**

   ***DMHMRSAS Response:*** *As reported in our response to recommendation #3, the MR Special Populations Workgroup has been charged with developing a methodology to assist the Department's comprehensive planning for the MR population. Included in this workgroup are parent, advocate, private provider, state facility and CSB representation. More recently, a representative of the Department's Office of Architecture and Engineering has been added to the workgroup. The methodology, when applied in the regions, should provide data that identifies projected census, population(s) to be served, and services at the Training Centers. Concurrently, a review of physical plant design development is being undertaken. Since form follows function, the plant design process also will require identification of the specific populations to be served. The result of this work will be integrated into the Capitol Improvement submissions, which will be due to the Governor in June 2005.*

9. **It is recommended that each training center develop a process for routinely seeking evaluative comments from consumers, families and community providers regarding the quality of services provided by the facility, the**

**effectiveness of the facility's relationship with the broader provider service system, and general satisfaction with services.**

**Refer to section entitled Community Relationships on pages 33 through 35 of Report #107-04 and see individual facility reports for background on recommendation 9.**

***DMHMRSAS Response**: The Department recognizes the importance of feedback from family members, consumers and community providers in the continuous quality improvement efforts for MR facilities. Thus, the Office of Mental Retardation will collaborate with the Office of Facility Operations/QA in convening a group of facility representatives, advocates, family members and providers. The purpose of this group will be to develop instruments that provide facilities and the Department with a broad range of information and feedback concerning service quality and effectiveness. As part of this process, each facility will identify current mechanisms in place for receiving feedback, and will determine revised or new methods to enhance feedback opportunities that are most useful to its region and its stakeholders. It is anticipated that testing of these instruments could occur in September 2005.*

**SOUTHSIDE VIRGINIA TRAINING CENTER**
**August 19–20, 2004**
**OIG Report #102-04**

**INTRODUCTION:** The Office of the Inspector General (OIG) conducted a primary inspection of Southside Virginia Training Center during August 19-20, 2004. The inspection focused on a review of the facility through the application of thirty-two (32) quality statements divided over five (5) domains. The quality statements were formulated with the input of a number of stakeholder groups. These groups included the five training center directors, parents and advocacy groups, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Retardation Services staff, and directors of mental retardation services for community services boards. The quality statements address the facility's mission and values, access to services, service provision, facility operations and community relationships. The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into five primary sections focusing on each of the domains.

**SOURCES OF INFORMATION:** Interviews were conducted with twenty-nine members of the staff, including administrative, clinical and direct care staff. Tours were conducted in selected residential cottages and in on-site day treatment/training program buildings. The documentation reviews included, but were not limited to: five (5) clinical records, including approved behavioral plans; selected policies and procedures; staff training curriculums; and the facility quality management and strategic plans.

## MISSION AND VALUES

**1. The facility has a clear mission statement.**

Interviews were conducted with twenty-nine staff members including administrative, clinical and direct care staff. All those interviewed had a working understanding of the facility's mission. Two members interviewed specifically referenced the use of person-centered planning as a key element in the facility's ability to meet its mission of providing quality individualized services. Other phrases used to describe the mission included: the provision of high quality services with the resources available, the protection of the residents, the provision of treatment designed for skills development and eventual community placement and the provision of campus-wide support services.

The facility's mission statement is that "SVTC is committed to excellence in providing quality, client-centered health and habilitative services for individuals with mental retardation. We provide a client-focused learning and living environment that positively affects the lives of the clients we serve. We extend our commitment beyond the facility to the wider community through service initiatives and partnerships of mutual interests addressing campus, local and regional opportunities and challenges. We provide administrative and environmental support services to Central State Hospital, Hiram W. Davis Medical Center, and Virginia Center for Behavioral Rehabilitation." It was

reported that the mission statement was last reviewed during a 2003 retreat, which included members of the Executive Steering Committee (ESC).

**2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.**

Respect, both for each other and the residents, was most frequently identified as a fundamental value that functions as the basis for all of the services provided by the facility. Other values shared during the interviews included: good communication, teamwork, client-focused services, striving to understand each other's job and a sound work ethic. The facility has a written values statement that includes but is not limited to the following values: the focus on the customer, showing respect, the importance of decision-making processes, responsibility at all levels of the organization, effective leadership, integrity and employee involvement as a means to quality improvement.

Seven of the persons interviewed cited the employee forum as an example of how the facility has operationalized these values. It was reported that this forum provides a respectful setting for staff to learn about and understand the role and function of other employees, communicate concerns and participate with management in the resolution of issues.

Staff on all levels from direct care staff to the facility director indicated the problem with "holdovers" as one of the significant issues facing this facility. This was one of the main issues discussed by the majority of staff during the previous inspection conducted by the OIG. The staff interviewed were noticeably less angry about this concern than during previous inspection interviews. The majority of staff maintained that decreased anger and frustration resulted from increased communication between staff and management. The interviews revealed that since the last inspection, management has provided a variety of avenues for staff to identify and address concerns. This has significantly decreased their sense that management does not have an understanding of or concern for their frustrations.

## ACCESS / ADMISSIONS

**1. Policies and Procedures that govern admission are consistent with the facility's mission statement.**

The OIG reviewed policies governing admission for consistency with the facility's mission statement. The policy outlines admissions procedures that are based on individualized client needs. The facility review of an applicant focuses on ways in which the training center setting will support the person's stability and growth. Admissions policies are based on both the DMHMRSAS Departmental Instruction (101TX96) and the Admissions and Discharge Protocols established to guide both the facilities and the community services boards (CSB). The policies and procedures are consistent with the facility's mission to provide client-centered health and habilitation services.

**2. Admission to the facility is based on a thorough assessment of each applicant's needs and level of functioning.**

Interviews with staff, a review of five resident records and a review of the facility policy that governs admissions demonstrated that the facility has an established mechanism for reviewing prospective admissions that is based on a thorough assessment of each applicant's needs and level of functioning in order to assure that institutional placement is appropriate.

Interviews indicated that it is the responsibility of the referring CSB to assure that the least restrictive alternatives to institutionalization are identified and considered prior to the application process. Once admission to the facility is sought, the Director of Community Services at the facility notifies the DMHMRSAS Office of Mental Retardation Services and convenes the Admission Advisory Committee. The committee reviews the application and assessments. The committee's decision is communicated to the Facility Director who has 30 days to notify the CSB of the decision. If it is determined that the client is not suitable for admission, the reasons for the denial of the admission are communicated in writing. If the consumer is accepted for admission, then the facility must seek judicial certification of eligibility. This process certifies that the person is eligible for admission, enabling the facility to accept the resident.

The community completes a number of assessments prior to admission, which are used as reference points for determining whether the applicant is appropriate for admission. Interviews indicated that the community assessments conducted and submitted as a part of the admission process include, but are not limited to:

- Current medical status including immunization history and psychiatric evaluation
- Psychological assessment (less than 3 yrs)
- Social history
- Individualized Educational Plan (IEP) for those 2 through 21
- Vocational evaluation (if in a community day program)
- Prescreening Report (including identification that no less restrictive alternative exists, training recommendations and discharge plans)

Eight (8) admissions were completed from July 2003 to July 2004. There was one person on the waiting list for admission to the facility as of July 1, 2004.

At the time of admission, the facility conducts its own assessments of the resident in order to develop the individualized habilitation plan. Assessments conducted include a nursing review at the time of admission and a complete medical examination (within 24 hours). Assessments by other disciplines include but are not limited to: psychology, occupational therapy, physical therapy, nutritional assessments, social services, and risk assessments such as falls.

**3. The facility has a mechanism in place for addressing emergency admissions.**

Interviews and a review of applicable policies and procedures demonstrate that the facility has a mechanism for addressing emergency admissions. Emergency care as defined by the facility policy is subject to the same review processes as regular admissions. Even though the facility uses much the same process as with regular admissions, the timeframe is much narrower due to the emergent nature of the applicant's condition. Interviews revealed that for the emergency admissions sought during the past year, most involved an unexpected or imminent change in the individual's living situation or environment, posing an increased risk of physical or emotional harm to the applicant.

It was learned that SVTC makes every effort to facilitate emergency admissions that are deemed appropriate as quickly as possible. Some of the factors those influences the speed in which the admission can occur include: the nature of the emergency, the gender of the client, and the availability of space. Clients with mental retardation who are experiencing acute symptoms of mental illness are more likely to be referred for emergency admission to Central State Hospital (CSH) where the services are considered by the training center staff to be a better fit.

During the last fiscal year, there were eight (8) requests for emergency admissions of which five (5) were admitted.

## SERVICE PROVISION / CONSUMER ACTIVITIES

**1. Activities are designed to facilitate socialization, skills acquisition and community integration.**

Five resident records were reviewed during this inspection. All of the records outlined individualized goals consistent with the tasks identified in this quality statement. The prescribed objectives depended on the resident's degree of impairment and level of functioning. Individual strengths and preferences were utilized in the development of each resident's individualized habilitation plan (IHP).

The Office conducted a tour of and spent time observing habilitation services offered in Buildings 66 and 81. Interviews were conducted with eight staff members and one resident. The staff were knowledgeable of the goals and activities identified for each resident. Staff were observed treating the residents with dignity and respect as well as interacting with them in a loving and gentle manner. Staff spoke with pride of the accomplishments of the residents but also seemed to have realistic expectations regarding each person's ability. The activities observed were designed to strengthen fine motor skills, increase communication, support socialization skills and decrease the maladaptive behaviors that are identified as barriers to successful community living for the residents.

**2. Residents are actively engaged.**

Tours during this inspection occurred in both residential and training/active treatment areas during the evening and daytime shifts. During the evening tour, residents were having dinner or working on leisure/skills development activities. Residents were engaged in small group activities such as story telling and crafts. Observations also occurred during the morning activities, which included attending to the activities of daily living, having breakfast and generally preparing for the day. All of the residents in the areas toured during the morning were scheduled to go to either day treatment activities in the habilitation programs or pre-vocational services. Staff were supportive and assisted residents in accomplishing their tasks. The interactions observed were designed as learning opportunities and not simply staff doing the tasks for the residents.

**3. Activities occur as scheduled.**

Day treatment programming was noted to occur as outlined on the residents' schedules. Staff indicated that the majority of activities occur as scheduled except when staff shortages result in a delay. Staff indicated that delayed activities were completed as soon as staffing patterns allowed.

**4. Residents are supported in participating in off-grounds activities.**

Interviews with staff revealed that the residents have opportunities to participate in individual and small group activities in the community, such as going shopping, to the park, for rides, out for dinner and to Kings Dominion. Evidence of community integration activities was also noted in all of the resident records reviewed.

**5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.**

Interviews indicated that the facility plays an active role in discharge planning for the resident. Residents are encouraged to visit community placement options, including extended visits designed to determine how well the resident will function in a new setting. Facility staff work with community staff in aiding the resident's acclimation to the new environment but these services are very limited due to resource constraints. Staff offer consultation services for residents who have been recently discharged as well as community residents that are at risk of losing their placements in a effort to help the person(s) remain in the least restrictive setting possible.

## FACILITY OPERATIONS / SAFE ENVIRONMENT

**1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.**

SVTC has multiple ways of assessing and monitoring the safety and security of the residential units. The facility is unique across the state facility system in that it is the

only facility that has its own police force and fire department. The officers and firemen are responsible for the entire campus security, which includes Southside Virginia Training Center, Central State Hospital, Hiram W. Davis Medical Center and the Virginia Center for Behavioral Rehabilitation. The police conduct perimeter checks including routine rounds of the grounds and buildings. Security and fire safety personnel monitor the campus and conduct regular safety inspections.

The facility has an Environmental Safety Committee that reviews and monitors a number of environmental factors. The facility's Buildings and Grounds Department has a system for addressing work orders. This system prioritizes requests based on the level of risk involved. Life, health and safety concerns are addressed immediately. Routine work orders are targeted for completion in seven working days or less.

The facility has a risk manager who reviews and tracks critical incidents and other areas of concern. Data is collected that enables the risk manager to conduct analysis of a variety of factors. The risk manager shares this information with the Executive Steering Committee during morning reports. The morning reporting process outlines significant events for the previous 24 hours. Members of the management team are present at the meeting and address issues as identified.

**2. There are adequate safeguards to protect residents from abuse and neglect.**

Interviews indicated that the facility adheres to Departmental Instruction 201(RTS) 03 (Reporting and Investigating Abuse and Neglect of Clients), which governs the procedures for reporting and investigating allegations of abuse and neglect. The facility's abuse and neglect investigator is a member of the police force and is specifically trained.

Allegations are reported to the facility director who forwards the allegations to the investigator for review and follow-up as appropriate. The human rights advocate reviews all allegations of abuse and neglect and monitors the investigation process on behalf of the consumer.

Relevant staff training focuses on issues associated with abuse and neglect and client-centered approaches to care. Staff throughout the facility were observed treating the residents with dignity and respect.

The facility director is featured in a video that provides a clear message regarding management's stand on not tolerating abuse and neglect within the facility. It also is a tool for reinforcing the values of dignity and respect.

During the first six months of 2004, there were 45 allegations of abuse and neglect, of which 21 were substantiated.

**3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.**

The risk manager tracks critical incidents. This includes those incidents that fit the criteria for reporting to VOPA and those that impact patient safety but do not result in injuries such as sometimes occurs with resident falls and incidents of peer-to-peer aggression. Data is collected and routinely communicated to management and staff. Performance improvement teams have been designed to address issues identified through this process.

Nursing maintains data on critical indicators such as the number of pressure ulcers, the number of residents that require special hospitalization, the number of persons that have been diagnosed with dehydration, and the number of medication errors. The information is used to identify possible areas in which additional training or supervision may be needed. The facility conducts routine safety checks of the physical plant and prioritizes issues that have life, health and safety implications. These are addressed immediately.

Data provided by the facility indicated that there were 27 critical incidents reported to VOPA and the OIG from January to June 2004. There were 89 incidents of peer-to-peer aggression during the same reporting period, of which 60 were noted as resulting in injuries to one or both of the residents involved.

**4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.**

Interviews revealed that SVTC rarely uses locked or isolated time-out with its residents. Isolated timeout is defined as "the removal of a client from ongoing reinforcement to a specifically designated time-out room." SVTC complies with CMS regulations, which outline the circumstances under which ICF/MR facilities can use the time-out room. These include:

- The use of the time-out room has to be a part of an approved systemic time-out program.
- The use of the time-out room can not be used as an emergency intervention,
- The client is under direct constant visual supervision while in the time-out room
- The door to the time out room is held shut by staff or by a mechanism requiring pressure from staff

Exclusionary time-out is utilized only when the resident's behavior is identified as maladaptive and occurs only as outlined in the resident's behavioral plan. The Local Human Rights Committee reviews all behavioral plans that call for the use of restrictive procedures. Information provided by the facility reported there have been four incidents of isolated time-out at the facility since January 2004. There were also four incidents in which emergency mechanical restraints were used. Interviews indicated that during the second quarter of 2004, there were 197 residents with approved behavioral plans, four of which had restraint or isolated time out as a part of the plan. There were also 360

residents with protective restraints, 53 of which required the use of a wheelchair during transport.

**5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.**

Human Rights training is provided for all staff at the time of their orientation and annually thereafter. Residents and their legally authorized representatives are advised of the rights and the complaint process at the time of admission and at least annually. Documentation of this notification was in the resident records reviewed.

The facility has both an informal and formal process for handling complaints. The facility director handles informal complaints. The team was able to actually observe the informal complaint process. Complaints that are brought directly to the advocate's attention or informal concerns that cannot be resolved at the facility director level become formal complaints and are handled as outlined by the Human Rights regulations. The facility director notifies the advocate of the informal complaints and how they are resolved. Interviews revealed that these were addressed in a timely manner. During the first six months of 2004, there were 9 informal and 3 formal complaints handled within the facility.

**6. Medication usage is appropriately managed.**

The facility has established policies and procedures for the handling of medications. Medication errors are tracked through the development of performance improvement indicators designed to promote the reduction of errors. The 2004 Nursing Annual Report indicated that the average number of medication errors reported for this year was .015 errors per client per month. The report indicated that with over 3000 medications (not doses) given every day, it was decided that a performance improvement process would be initiated to assure that accurate reporting of errors is occurring. The performance improvement initiative has been designed to capture enough data regarding medication administration to increase confidence in the errors rate. Increased education and training regarding what constitutes an error and when to report will be components of the initiative. Also supervisors will be conducting periodic and random reviews of medications practices and/or cart counts. Interviews with staff described adequate safeguards in both the management and administration of medications.

The first safeguard in assuring that medication is managed appropriately within the facility is training. The facility uses a curriculum approved by the Board of Nursing. Staff must pass written tests and demonstrate competency in a number of areas regarding the use of medications. Ongoing supervision regarding competency is a component of staff performance evaluations.

**7. There are mechanisms to address areas of concern regarding staff safety.**

There is an expectation at the facility that staff injuries are to be reported in a timely manner even though it was acknowledged by nursing and mid-management that this varies in practice across the facility. The Human Resources Department tracks the injuries, as well as monitors those that result in claims, absences and disability.

The Safety Committee addresses issues identified as staff safety risks. Environmental safety checks identify and correct physical conditions that could have an impact on the safety of both the staff and the residents. Staff may notify their supervisors, the risk manager or facility safety officer regarding identified areas of risk within the facility.

## FACILITY OPERATIONS / LIVING ENVIRONMENT

**1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.**

Efforts at personalizing the residents' rooms were evident. Staff described additional projects currently underway for obtaining additional items that were requested by the residents.

Blinds for privacy are used in resident's bedrooms and the common areas. Other materials are used for the same purpose when behavioral and/or safety concerns are identified.

**2. The residential environment is clean, odor free and well maintained.**

Tours of Cottages 16, 17, 26 and 27 revealed that the residential areas were clean and well maintained. The furniture was appropriate for the number of residents and population served. Bathrooms were clean and odor free.

A small electrical gadget of undetermined purpose was noted on the wall in a resident's bedroom in Cottage 26. Staff indicated they would submit a work order to have the object either repaired or removed. In checking the following day, it was determined that this had been addressed.

The facility identified that following as the three most critical capital improvement projects:

- Renovations to the cook-chill system (estimated cost $2.2 million)
- Phase three of the work on the steam distribution systems (estimated cost $1.5 million)
- Sanitary and sewer system improvements (the estimate is unknown as the work needed is in the process of being evaluated)

The facility is currently addressing the following projects:

- Project number 720-16373-01 on the steam tunnels which is 99% completed
- Project number 720-16373-02 regarding a boiler replacement, which is scheduled for completion in July 2005
- Project number 720-16156-01 on HWDMC fire alarm system that is 98% completed.

**3. There is evidence that the residents are being taken care of by the facility.**

Throughout the tours, the team had an opportunity to observe the residents. All were properly clothed, clean and appeared well provided for by the facility. Observations of the interactions between the staff and the residents revealed that the staff treated the residents with dignity and respect. Staff related to the residents in a caring yet professional manner.

**4. The facility provides for access to primary health care that is coordinated and comprehensive**.

On the day of the inspection, there were 384 residents. The facility has four (4) primary care physicians and the facility medical director. The caseload for each physician is approximately 1 to 95. The medical director maintains a caseload of approximately 20 persons. In addition, residents have access to a number of clinic services through Hiram W. Davis Medical Center or the Medical College of Virginia. The facility uses either Southside Regional Medical Center or the Medical College of Virginia for special hospitalization and emergency services. The facility has part-time psychiatric coverage, which provides services for those individuals at the facility who are dually diagnosed.

SVTC has a clinic, which maintains 24 hour nursing coverage. All residents identified as needing care are seen in the clinic except for emergencies. In the event of an emergency, the RN is the first responder contacted but staff are trained to make basic assessments and contact the local rescue squad as appropriate, prior to the arrival of the RN on the unit. Each unit has nursing coverage during the day and evenings, but the clinic nurse provides coverage during the night shift for the two units that do not have a nurse assigned to the unit during that shift.

There is no physician on-site during the evening or night shifts, but an on-call system is utilized for providing coverage. Nursing staff reported an excellent response time by the on-call physicians, usually less than five minutes.

**5. The facility has a mechanism for accountability of resident's money.**

There is a patient accounts division under the facility's Office of Fiscal Management that maintains records of the patient's money. Each person's qualified mental retardation professional (QMRP) is responsible for tracking the management of the resident's funds. Receipts are required in order to maintain accountability for items purchased either by the residents or on behalf of the residents.

## FACILITY OPERATIONS / STAFFING PATTERNS

**1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.**

Of the 15 staff members interviewed, all maintained that the facility was able through mechanisms such as "holdovers" and overtime maintain a sufficient qualified workforce to address the supervision and training needs of the residents.

During the tours, it was noted that in Cottage 26 and Cottage 27, there were 12 residents (six per side) and 5 staff members present. During the tours of Cottages 16 and 17, there were 16 residents (eight per side) and 6 staff present. Two of the staff present were programming staff that assist in the cottages during morning preparation activities then travel with consumers to the day programming activities. Three staff members indicated they were doing overtime from the previous shift.

The facility has been working to enhance its recruitment efforts. It was reported that on one day during the past six months, the facility was successful in having all of its direct service associate (DSA) positions filled, which was viewed by management as a huge accomplishment. Data maintained for 2004 revealed a significant decrease in the number of DSA position vacancies. The retention of staff is the next challenge identified by management for the facility. As recruitment efforts have improved and been sustained, the retention of staff has remained relatively the same. The facility has been increasingly successful in hiring and maintaining professional staff.

One supervisor, who is anticipating the loss of five seasoned employees (25 +years of service) due to scheduled retirement during the first quarter of 2005, expressed concern regarding the imbalance of new and seasoned employees that this will create in that unit. He related that new staff benefit tremendously by being mentored both formally and informally by seasoned and dedicated personnel. The supervisor indicated that it is primarily through time and contact that staff are able to recognize the resident's needs, preferences and communication styles.

**2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of resident supports and care.**

Management and direct care staff indicated that "holdovers" continued to be a major problem at the facility and one of the primary sources of staff frustration. During the inspection, there were ten holdovers in one building alone due to call-ins and the on-site working visit by a guardian ad litem, which required the availability of staff to assist in the transport of residents for meetings. Even though the event with the guardian is rare, the combination of call-ins, vacations, increased number of residents on 1:1 and staff out sick or on short term disability has keep the need for holdovers high. Management says that they are able to maintain a safe environment with adequate support, however, they

are limited in the number of activities they are able to provide the residents because of the holdover issue.

Staff expressed concern about the excessive delay between the time they work the overtime and when they are paid. Several related that this is often a six to eight week delay. Two employees said that the delay in compensation made it very difficult to track for accuracy. One staff member interviewed indicated that it took considerable effort to demonstrate she had not been accurately compensated for the overtime work performed.

**3. Direct care staff possesses the competencies necessary for providing services.**

Interviews with training and supervisory staff, as well as a review of the training materials revealed that the majority of critical tasks associated with staff duties required competency reviews, which involved either tests or demonstrations.

## FACILITY OPERATIONS / SYSTEM PERFORMANCE

**1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.**

Interviews revealed that the facility views the expertise housed in its information technology department as essential to its ability to streamline care in order to provide more effective and efficient services to the consumers. One example provided was the development of an automated record keeping system for writing and maintaining individualized habilitation plans (IHP). This system gives qualified mental retardation professionals the ability to create consumer plans of care online using a menu of options. The design supports the development of individualized plans but allows for required categories to be completed with greater accuracy and ease. Staff are in the process of being trained on how to use the system. All those interviewed indicated that this system should dramatically reduce the time spent in completing paperwork, which was identified as an issue by staff.

Data collection is used in a wide variety of ways to track trends in key areas by the facility. Some of the indicators tracked through data collection include the percentage of IHPs developed on time; the number of residents without legally authorized representatives; the number, type, location and time of critical incidents; incidents of peer to peer aggression; medication errors; and medication usage.

**2. There is a system for continuous quality improvement (QI).**

SVTC has a well-defined and managed quality assurance process. The QA strategic plan has four goals and annually defined strategies for meeting the goals established. A quality subcommittee has been established to monitor the completion and outcomes of strategies in each of the four goal areas. These committees report to the Executive

Steering Committee. Data is collected and analyzed by each subcommittee to determine if there is evidence that improvement towards the identified goals is occurring.

**3. Consumers and other stakeholders have an active role in program development and quality improvement activities.**

Families are not a formalized part of the quality assurance process within the facility. The facility does have a very active parents organization, Parents of SVTC, which meets regularly with members of the facility management staff. Members of this organization are asked to provide feedback to the facility.

## COMMUNITY RELATIONSHIPS

**1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in their catchment area.**

Most of the work that surrounds maintaining community relationships occurs as a result of providing services to the residents through the admissions, discharge and outreach processes. The frequency of interactions is expected to increase dramatically with the anticipated discharges through the 60 waiver slots recently allotted to the facility. The Director of Community Services indicated that there is already some pressure being exerted by the community for the facility to move more rapidly than it is prepared to move on facilitating the discharges. It is the facility's plan to discharge those identified over the next two years or sooner as the community services boards become ready to receive them. One community services board was reported as having identified placements and has asked to begin the discharge of six of their residents. The strategies for successfully completing this task had not been addressed between the community and the facility at the time of the inspection.

SVTC maintains a very active relationship with the CSBs in Region IV. The facility director meets regularly with the CSB executive directors and other staff work actively with the CSB mental retardation director. Over the past several years, SVTC has been a key player working with the CSBs through the reinvestment/restructuring initiative to modify services within the facility to meet community needs. Several new programs have been created.

**2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders:**

**a. With Community Services Boards**

Even though there has not been a formalized survey conducted with the community services boards, there are a number of informal mechanisms for identifying the community's satisfaction with the services provided.

**b. With parents and/or legally authorized representative**

The facility has conducted satisfaction surveys with the families of residents. The survey was not conducted last year because it was reported that the Central Office

completed a survey for the facilities. Facility staff indicated that they did not receive any feedback regarding the outcome of the survey.

**c. With the DMHMRSAS Central Office**

The facility indicated that it sends its annual plan to the Central Office yearly but to-date has never received any feedback regarding the document or the outlined plan of action.

It was indicated that the risk manager at the facility has the most contact with staff at the Central Office through ongoing meetings and reviews of the work associated with the overall risk management process.

The facility director has regular contact with Assistant Commissioner for Facility Operations and other facility directors during informal and formal meetings but the discussions rarely focus on the satisfaction of the Central Office with the work completed by the facility nor do the meetings provide an opportunity for facilities to provide feedback to the Central Office about the effectiveness of the relationship. Of those specifically asked to address this statement, all indicated that more information would be helpful and welcomed.

**3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.**

Management at the facility had a good working understanding of the community's capacity to effectively address the needs of this challenging population. However, staffs' understanding of the current capacity of the community is not reflective of the more complicated clients that are being served at that level.

Nursing and medical staff identified a lack of trained and interested professionals in the community to provide the time-intensive specialized services needed by the residents as a major difference between the community and the facility in addressing the healthcare concerns of this special population. One example provided was routine dental cleaning, which usually requires anesthesia, proper positioning and more involved follow-up care. Current funding arrangements makes it difficult for the facility to provide this care for consumers who live in the community.

Direct care staff indicated that the community providers are unprepared to receive their residents and do not provide the staffing patterns necessary to maintain the skills residents have acquired in the facility. Eight of the ten interviewed indicated that the community chose to use medications instead of behavioral plans to address problems in the community, which the facility staff viewed as a failure for the resident. The majority of direct care staff interviewed did not have confidence in the community's ability to provide adequate care of the residents upon discharge. However, this perception is based primarily on their experience with the relatively few residents that have returned to the facility post discharge. The recidivism rate at this facility is low.

Interviews with staff revealed that they did not appear to have a common understanding of the facility's role within the community. Management described the facility's role as to provide a safety net for the community when the necessary resources for providing the services needed by the consumer cannot be provided in a less restrictive setting. Staff, however, indicated that it is the responsibility of the facility to provide services for any consumer with mental retardation that chooses institutional care.

**4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.**

The facility is not licensed to provide services for children (CORE license) so it cannot provide respite services for this population. All other age groups, including geriatric, are provided respite services. The facility had 6 requests for respite care last fiscal year and were able to provide services for all of them.

**SOUTHEASTERN VIRGINIA TRAINING CENTER**
**September 2-3, 2004**
**OIG Report#103-04**

**INTRODUCTION:** The Office of the Inspector General (OIG) conducted a primary inspection at Southeastern Virginia Training Center during September 2-3, 2004. The inspection focused on a review of the facility through the application of thirty-two (32) quality statements divided over five (5) domains. These include: mission and values, access, service provision, facility operations and community relationships. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the five training center facility directors, parents and advocacy groups, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Retardation Services staff, and directors of mental retardation services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. This report is divided into five primary sections focusing on each of the domains.

**SOURCES OF INFORMATION:** Interviews were conducted with thirty (30) members of the staff including administrative, clinical and direct care staff. Tours were conducted in selected residential cottages and in on-site day treatment/training program buildings. The documentation reviewed included, but was not limited to: three (3) clinical records, approved behavioral plans, selected policies and procedures, staff training curriculums, the facility quality management plan, selected minutes of the risk management committee, and the SEVTC budget presentation.

## MISSION AND VALUES

### 1. The facility has a clear mission statement.

It was reported by the numerous staff interviewed that the facility does not have a formally defined mission statement. However, the team was provided a copy of the facility brochure that had a mission statement included in its text. The brochure indicates that the mission "is to provide habilitation, training, educational and health services for eligible persons from Planning Districts 17, 18, 19, 20, 21, and 22."

Twenty staff members were asked to define the facility's mission. Most described the mission from the vantage point of their positions or the mission of their duties or unit. In addition, fifteen of the twenty individuals interviewed described the mission in terms of addressing the basic care needs of the residents such as proving safe housing, quality healthcare, proper nutrition, adequate clothing and recreational opportunities. Even though nineteen of the twenty staff persons interviewed indicated that addressing the training needs of the residents was a key element of the facility's mission, only seven linked the goal of the facility's services to the development of skills necessary for community placement. Some senior clinical staff reported being unsure what the mission of the facility is at this time. It was stated that the population of the facility has shifted so

dramatically over the past ten years, yet the programming continues to be designed for persons less behaviorally and physically challenged than those who are currently served.

It is of concern that there is widespread unawareness of the facility's formal mission statement and a lack of consistent understanding of the mission.

**2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.**

The facility brochure outlines that SEVTC subscribes to a philosophy that emphasizes "the importance of programming based on individual needs and the inherent right of every human being to dignity, respect, protection and the right to contribute to society according to his or her abilities."

Those interviewed identified teamwork, dignity and respect, adherence to professional standards and the provision of quality care in a safe home-like environment as the predominant values governing the services delivered by the facility. Administrative staff indicated that the facility subscribes to the normalization principle and that residents are entitled to the highest quality treatment that can be provided within the available resources. The team observed staff and resident interactions during the facility tours. Staff were noted to treat the residents in a professional yet caring manner.

Staff across the campus reported very different experiences regarding how often they see the facility director in their program areas. This ranged from every couple of weeks to every several months.

## ACCESS / ADMISSIONS

**1. Policies and Procedures that govern admission are consistent with the facility's mission statement.**

The OIG could not make a determination regarding this quality statement because the facility did not present a formalized written mission statement to the team at the time of the inspection.

**2. Admission to the facility is based on a thorough assessment of each applicant's needs and level of functioning.**

SEVTC Instruction Number 2001 provides the guidance for admissions to the facility. Four staff members were interviewed regarding the admissions process, which all described as "fairly standard across the system". Staff related that the 2003 Admission and Discharge Protocols serve as the basis for their admissions and discharge processes. SEVTC has a committee that provides oversight of the admissions process, including making recommendations to the facility director regarding whether the applicant is appropriate. A social worker/community liaison works with the appropriate placing

agency to obtain the necessary information by which the committee will determine the applicant's suitability for acceptance (SEVTC Instruction Number 2000). This includes such information as a recent psychological, family and social history, and medical information. Once the committee has submitted its recommendations, the facility director makes a final determination regarding the applicant's suitability for admission. It is the responsibility of the facility director to advise the appropriate CSB of the outcome of the admissions review. A notification letter is sent outlining the decision. In the case where the application is rejected, the letter states the reasons for the denial and provides suggestions for either alternate placement or other services.

Upon admission, the new residents will undergo a series of assessments by the various disciplines within the facility. The assessments serve as the basis for the individualized habilitation plans. All three (3) of the records reviewed contained the assessments described by policy. The record reviews demonstrated that the assessments and identified needs of the resident serve as the basis for the development of the plans.

Five (5) regular admissions had been completed to the facility during the past year. It was reported that at the time of the inspection there were three (3) additional approved admissions awaiting a space in the facility as of July 1, 2004.

**3. The facility has a mechanism in place for addressing emergency admissions.**

SEVTC Instruction Number 2014 governs the admission of emergency placements. The instruction defines emergency care as "a legal status assigned to an individual admitted to an MR training center for a limited time without the judicial certification process. Admission is limited to 21 consecutive days or 75 non-consecutive days in a calendar year". It was indicated that the process for acceptance of an applicant as an emergency admission is similar to the regular admissions process, except abbreviated.

Twenty requests for emergency admission were made during the period from 7/1/03 to 7/1/04, of which one was determined suitable for acceptance. Senior staff expressed concern that the facility was not more readily accepting emergency admissions. One senior staff member reported that a number of individuals described as unsuitable for community living because of maladaptive behaviors, such as aggression, have been referred for short-term stabilization and training but not accepted. Examples of community clients that had been turned down, which staff felt could have been served by the facility with special accommodations, were provided to the team.

## SERVICE PROVISION / CONSUMER ACTIVITIES

**1. Activities are designed to facilitate socialization, skills acquisition and community integration.**

The team reviewed three clinical records. All of the records contained individualized goals consistent with the tasks noted in this quality statement.

Tours included a walk-through of a day treatment program and both day and evening cottage based activities. Interviews with staff revealed that even though the scheduled activities were designed primarily for groups, individualized skills training programs were occurring within the prescribed activity. Interviews with the staff and a review of the residents' training workbooks revealed that the trainings were occurring as outlined. For example, during the tours of the cottages that occurred during the evening shift, the primary group activity was entitled Movement to Music. Staff engaged all residents in the activity but spent time with each person working on an individualized task, such as following instructions or increasing gross motor skills. Staff was knowledgeable of the goals and activities for the residents. Staff were observed treating the residents with dignity and respect. Overall the activities were designed to strengthen motor skills, increase communication, facilitate following instructions, support socialization skills and decrease maladaptive behaviors.

The majority of training activities for the residents at SEVTC occur in the residential areas because there is limited space for programming available on campus. The programming space limitation is a distinct disadvantage for the residents at this facility.

**2. Residents are actively engaged.**

As previously noted, tours were conducted in both residential and training/programming areas. Residents were engaged primarily in groups in each of the areas toured. Because of the limited staffing available, most of the residents were idle while staff were working with one or two persons. The activities varied depending on the level of functioning of the residents. Interviews revealed that approximately 80% of the facility's residents are engaged in some form of pre-vocational or vocational training activity. The number of hours in which each person participates varies depending upon the resident's level of functioning and the work available. One of the challenges facing the facility is maintaining adequate work activities in order to keep the residents actively engaged. The facility continues in its efforts to cultivate "piece-work" opportunities for the residents, however, a number of community organizations that have utilized the facility in the past are no longer doing so.

During the evening tours, after the residents completed their involvement in the movement to music activity, they were observed watching videos, going on a group walk outdoors or resting in their rooms. During this unstructured period, staff were also observed assisting residents with bedtime preparation tasks.

**3. Activities occur as scheduled.**

Programming was noted to occur as scheduled. Staff was familiar with the schedule and indicated that efforts were made to assure that activities occurred as planned.

**4. Residents are supported in participating in off-grounds activities.**

Interviews with staff revealed that the residents have opportunities to participate in individual and small group activities in the community, such as going shopping at the local mall, to the area parks, out for rides, attending picnics off grounds and going out for dinner. The team was informed that several residents had traveled to Busch Gardens for the day. This was identified as one of the favorite activities of the residents and staff. Evidence of community integration activities was also noted in all of the client records reviewed.

**5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.**

Interviews indicated that the facility currently serves residents from thirteen (13) community services boards. Three of the boards have only one resident at the facility. Both a facility social worker and the resident's CSB case manager are actively involved in the coordination of the discharge plans. Written pre-discharge plans identify each resident's needs and outline the type of setting and services the resident will most likely need upon discharge. These plans are updated periodically but no less often than annually.

Interviews revealed that it is the philosophy of SEVTC to provide residents preparing for discharge with adequate opportunities for visiting prospective placements so as to ensure a smooth transition to community living. Residents are encouraged to visit community placement options, including extended visits designed to determine how well the resident will function in the new setting. Facility staff work with community staff in order to assist the resident in adjusting to the new setting. These services, however, are limited because of the staffing patterns within the facility.

## FACILITY OPERATIONS / SAFE ENVIRONMENT

**1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.**

SEVTC has multiple ways of assessing and monitoring the safety and security of the residential units. The facility's Building and Grounds Department conducts monthly safety checks of each of the buildings. Workers undergo specific safety training in addition to the overall training provided by the facility to all staff. The facility has a procedure in place for addressing work orders, which prioritizes work according to the potential risk to the residents. Issues that would impact the life, health or safety of the residents are addressed first.

The facility has a Risk Management Committee that meets monthly to review areas targeted for monitoring and any other issues identified by staff. A review of the committee's minutes demonstrated that the committee addresses such topics as falls, resident-to-resident aggression, and emergency procedures. The committee develops plans of action and these are tracked until completed. The facility risk manager is a member of the committee and advises the group each month about the previous months

critical incidents. The risk manager collects data on a number of variables. This is also shared with the group.

The facility has a morning reporting process that outlines significant events for the previous 24 hours. Members of the facility management team are present at the meeting and address issues as identified.

**2. There are adequate safeguards to protect residents from abuse and neglect.**

Interviews indicated that the protection of residents from abuse and neglect is addressed in several ways within the facility. Staff are educated about the rights of the residents as well as the identification and reporting of abuse and neglect during their preservice training. All staff receive annual updates in these areas. It was reported that the staff also receive Therapeutic Options for Virginia (TOVA) training, which provides skills building activities in effective communication and use of positive interventions in challenging situations so that the use of more restrictive procedures can be lessened.

Interviews with administrative and training staff indicated that the facility promotes the treatment of this vulnerable population with dignity and respect throughout all training experiences. Management of the facility reported that the abuse or neglect of the residents would not be tolerated. Management communicates to staff that the response to substantiated abuse and neglect will be definitive. Management also reports that efforts are made to promote an environment in which people will come forward to report these conditions. It was indicated that this is best accomplished by treating staff fairly. Interviews revealed that management works hard to convey to staff an understanding that their jobs are difficult and that as incidents occur, every effort will be made to get to the truth.

Every morning the facility director, human rights advocate, risk manager and other senior managers meet to review the significant events for the preceding day, including critical incidents. Interviews revealed that the facility director has instructed the risk manger to informally review all events within the first 24 hours to rule out abuse and neglect as a potential component. This includes unexplained injuries. If this review results in a "reason to suspect abuse and neglect", the risk manager files an allegation. An investigation is then conducted. The advocate reviews all allegations of abuse and neglect and monitors the investigation on behalf of the consumer.

Interviews revealed that the facility director takes the investigation process very seriously. The director reviews the findings with senior management in order to identify any performance improvement initiatives that could prevent the incident from occurring again. There were 13 allegations of abuse and/or neglect made during the first six months of 2004. One of the allegations was substantiated.

**3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.**

The facility risk manger tracks critical incidents, both those that fit the criteria for reporting to VOPA and those incidents that impact patient safety but do not result in injuries such as the number of falls and peer to peer aggression. Thirty-four critical incidents were reported by this facility during the first six months of 2004. In addition, there were 141 incidents of peer-to-peer aggression, all of which resulted in an injury to one of the residents involved. Many of the injuries were minor cuts and abrasions, which did not require physician intervention. Performance improvement teams have been designed to address issues identified through this review. As noted above, the risk manager, facility director, abuse and neglect investigator, and the advocate meet every morning to review all incidents. As a result of this meeting additional information regarding events is sought through a variety of avenues.

An active healthcare system was identified as one of the mechanisms used by this facility to safeguard the residents from critical or life threatening incidents. In-service training designed to teach all staff how to recognize health problems in this population is routinely offered. Recently the facility upgraded its medical emergency response system. A nurse response team, comprised of two nurses on each shift, is available to address any emergencies on campus. The response team is dispatched through the admission office.

**4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.**

Interviews with both administrative and direct care staff provided evidence that the facility implements restrictive procedures according to the policy. SEVTC uses isolated time out within the facility. Isolated timeout is defined as "the removal of a client from ongoing reinforcement to a specifically designated time-out room." SEVTC complies with the CMS regulations, which outline the circumstances under which ICF/MR facilities can use the time-out room. These include:

- The use of the time-out room has to be a part of an approved systemic time-out program
- The use of the time-out room can not be used as an emergency intervention
- The client is under direct constant visual supervision while in the time-out room
- The door to the time out room is held shut by staff or by a mechanism requiring pressure from staff

Staff members in the behavioral cottage were able to identify the circumstances in which residents would be placed in isolated time out. The circumstances, as explained, were consistent with policy. Staff reported that they try less restrictive interventions before initiating isolated time out. SEVTC used isolated time-out 529 times during 2004. The maximum number of times any of the other 4 training centers used this most restrictive technique during the same period was 15 times.

Staff receive training in behavioral management. Staff related that as a safeguard, procedures have been established for the use of restrictive interventions. Any restrictive procedures that are to be used must be contained in an approved plan that is monitored by a qualified mental retardation professional (QMRP). There were 104 residents on approved behavioral plans at the facility during June 2004. At the time of the inspection, the team was informed that 95 residents had been prescribed a protective restraint.

**5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.**

Human Rights training is provided for all staff at the time of their orientation and then again annually. Residents and their legally authorized representatives are advised of the human rights process at the time of admission and at least annually. They are provided with a copy of the human rights "blue book". Documentation of notification of their rights was noted in the resident records reviewed.

The facility has both an informal and formal process for handling complaints. The facility handled four informal complaints and 2 formal ones during the first six months of 2004.

**6. Medication usage is appropriately managed.**

Interviews with nursing supervisors and direct care staff revealed that staff are trained in medication management, including recognizing potential side effects. This training was described as extensive and consists of modules designed to address issues required by the Board of Nursing for certification. All appropriate staff are also required to undergo an annual re-certification review.

Staff are expected to alert the primary nurse when any changes in the resident's health status is noticed. Logs are maintained regarding the administering of medications and are checked by unit supervisors. The psychiatrist and staff physician monitor the use of psychotropic medications. On-going pharmacy reviews provide an additional level of oversight regarding the use of medications to assure that they are appropriately managed. Medication errors are documented and reviewed. Additional training and supervision is provided as necessary.

**7. There are mechanisms to address areas of concern regarding staff safety.**

Interviews with administrative and direct care staff revealed that staff at the facility are expected to report injuries in a timely manner. The facility Quality Management Committee tracks workplace safety issues such as staff injuries and workmen compensation claims. Data is maintained regarding the type of employee injuries, location where the injuries occurred and the staff positions involved. This information is reviewed in a number of arenas such as risk management, quality assurance, human resources and the facility's safety committee. Environmental safety checks identify and

correct physical conditions that could have an impact on the safety of the staff and residents. Staff are encouraged to report any areas of perceived risk for injury.

## FACILITY OPERATIONS / LIVING ENVIRONMENT

**1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.**

In all of the areas toured, there was evidence that the residents have the opportunity to personalize their spaces. Individual rooms are decorated with personal items such as pictures of families and outings or other events significant to the residents. There was evidence of a concerted effort to make the settings appear more home-like. Residents are afforded privacy. Blinds or window coverings are provided, although the majority of the blinds in Building 28 were broken.

**2. The residential environment is clean, odor free and well maintained.**

Tours were completed in Cottages 1A, 2A, 4A, two units in Cluster 5 and in Building 28. There was wide variation in the condition of the inside of the buildings toured. This ranged from obviously run down and not well maintained (Building 28) to units very well maintained (Cluster 5 units). This was true for both the general repair of the interior spaces (painting, walls kept in good repair) and for the cleanliness and neatness of the environment. All of the units were clean, generally well maintained and odor free, except for Building 28. In Building 28, there were three bedrooms in which several knobs were missing from the dressers leaving exposed screws sticking out of the wood. Two dressers were broken resulting in the drawer fronts hanging down. Blinds in a majority of the bedrooms were torn or needed repairs. In one section of the hallway, a number of ceiling tiles were missing. In one of the bathrooms, the shower floor was dirty and two of the toilets appeared unclean.

The outside of many of the buildings appeared to be in bad condition. Wooden panels on the outside were clearly weatherworn, even when the paint was in OK condition. Many roofs looked like they needed extensive work.

In general, the grass was cut. However, in the areas where the grass needed cutting, like around several parking areas, the grass was extremely high, suggesting that it had not been cut in several weeks. Around many of the buildings and in the flowerbeds there was tall grass and little evidence of efforts to keep these areas neat.

Interviews identified that the following are the three most critical capital improvement projects at the facility:

- To replace the roofs
- To have emergency generators installed
- The initiation of Phase One of campus renovations including the building of four cottages to replace the older outdated cottages currently used.

It was also identified that the facility did not have any projects that were currently approved and funded.

**3. There is evidence that the residents are being taken care of by the facility.**

Throughout the tours, the team had an opportunity to observe the residents. All appeared properly clothed, clean and well provided for by the facility. Observations of the interactions between the staff and the residents revealed that the staff treated the residents with dignity and respect. Staff related to the residents in a caring yet professional manner.

**4. The facility provides for access to primary health care that is coordinated and comprehensive**.

On the day of the inspection, there were 196 residents on campus. The facility has two primary care physicians including the facility medical director, and one nurse practitioner. The facility also has a part-time psychiatrist. In addition, residents have access to a number of clinic services.

SEVTC uses a system of primary nurses who are assigned to particular units/cottages. It is the responsibility of the primary nurse to manage the overall healthcare of the residents. The primary nurses coordinate appointments, track interventions and complete routine documentation regarding the residents' health status. SEVTC has an infirmary that maintains 24 hour nursing coverage. The first responder to an emergency is an RN. The facility recently upgraded its emergency response team to assure that two RNs are present at all times. There is no physician on-site during the evening or night shifts, but an on-call system is utilized for providing coverage. Nursing staff reports an excellent on-call physician response time of usually less than five minutes.

**5. The facility has a mechanism for accountability of resident's money.**

There is a patient accounts division under the facility's Office of Fiscal Management that maintains records of the patient's money. Each person's QMRP is responsible for documenting the use of all resident funds. Receipts are required in order to maintain accountability for items purchased either by the resident or on behalf of the residents.

## FACILITY OPERATIONS / STAFFING PATTERNS

**1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.**

Interviews with 12 staff members, including administrative, clinical and direct care staff indicated that the facility maintained sufficient qualified staff to address the safety and supportive care needed by the residents. The majority (7) indicated that the facility did not always have a sufficient complement of staff to create the active treatment environment necessary to address the training needs of the residents in a consistent

manner. They linked this to the challenges faced by the facility in recruiting staff. Six job fairs have been held at the facility in the past six months. Last June, during the first open house there were 150 persons present. Interviews were held and all the vacancies at the time were filled. The facility also tries to hire part-time pool employees to supplement regular staff when it is necessary.

During the tours, staffing patterns were as follows:

- In Building 28, the ratio of staff to residents was 4:1. There were 20 residents present and 5 staff members, one of which was a unit supervisor.
- In 1A, during the first shift, there were 6 residents present. Three of the residents on this unit had gone to Busch Gardens for the day, and one other was off the unit. Two staff members were present and an additional staff member was off the unit with a resident. In 4A and 2A, there was two staff present for eight residents during the evening shift.
- In 5A and 5B, there were 4 staff members present for eight residents.

Concerns voiced by staff about the absence of an active treatment environment in which the training needs of residents could be met were confirmed during the tour of the facility. First example: During the day shift, the OIG team observed a group activity in Building 28 for approximately 20 minutes. The group consisted of 13 residents and 2 staff members. Most of the residents were idle during the entire period observed. Second example: During the 2nd shift, OIG staff observed preparations for bedtime in Cottage 4A. One staff member was assisting a resident with a bath, while a second staff member watched the remaining 7 residents. Two of the 7 residents were clearly ready for bed. One was falling asleep at the table and the other kept stating that she wanted to go to bed. The second staff member responded by saying that she could go to bed as soon as she had her bath. The OIG team was informed that the resident was scheduled to get her bath next. This staff member said she felt guilty not being able to meet the resident's request but with only two staff available to work with the 8 residents, they were doing the best that they could. In both of these situations the number of staff required by the facility's established staffing ratio (2:8 on the 1st shift and 2:8 on the 2nd shift) was present. This level of staff deployment during the activities that were observed was not adequate to meet the training needs of the residents.

**2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of client supports and care.**

Interviews with administration, human resources and staff indicated that staff turnover for the facility is relatively low but that there is a great deal of competition for healthcare workers in the Tidewater area and that other employers pay higher salaries, which impacted the facility's ability to recruit employees. The facility maintains adequate staffing through overtime and part-time positions.

**3. Direct care staff possesses the competencies necessary for providing services.**

Interviews with training and supervisory staff as well as a review of the training materials revealed that the majority of critical tasks associated with carrying out staff duties are based on competency reviews, which involve either tests or demonstrations.
The level of competency required for most of the critical tasks is 90%. Those individuals who are not able to meet the criteria are provided with opportunities to learn the material and be re-tested.

## FACILITY OPERATIONS / SYSTEM PERFORMANCE

**1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.**

Data collection occurs in a variety of forms within the facility. Both risk management and quality assurance staff track a number of performance improvement measures. The Office of Information Technology was instrumental in the development of an automated record keeping system. In addition there is a database for the tracking of medication use.

**2. There is a system for continuous quality improvement.**

SEVTC has a system for continuous quality improvement. Information is tracked and reviewed by the Quality Management Committee at the facility. Some of the dimensions of care reviewed are preventative health screenings, medication errors, PRN usage, contractures, lab services, infection control, active treatment and use of behavioral procedures.

**3. Consumers and other stakeholders have an active role in program development, and quality improvement activities.**

Consumers and their families are not a formalized part of the Quality Assurance Process within the facility. However, interviews revealed that the facility is open to input from both. The facility director meets regularly with executives from the community services boards in the region.

## COMMUNITY RELATIONSHIPS

**1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in their catchment area.**

Most of the work that surrounds maintaining community relationships takes place in the context of the interactions that occur as a result of providing services to the residents through the admissions, discharge and outreach processes. As noted, the facility director meets quarterly with the executive directors of the community services boards in the region. In addition, he meets with the CSB MR Directors monthly. Staff from the

facility provides consultation to community providers in order to assist them in managing their more challenging consumers but this does not happen with the frequency that facility staff would like because of the lack of resources to support this activity.

**2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders:**

**a. With Community Services Boards**

No formalized surveys have been conducted with the CSBs

**b. With parents and/or legally authorized representatives**

The facility has not conducted any formal surveys with families but solicits feedback from them regularly on an individual basis. It was indicated that families are very willing to discuss any issues or concerns when they arise. They also are noted for praising the work of the facility, when appropriate.

**c. With the DMHMRSAS Central Office**

The facility indicated that there has not been a formalized satisfaction survey process completed with the CO other than the director's performance evaluation and at times when there are budget requests. It was noted that the CO has proven to be a valuable resource for the facility in the following areas: human resources, the budget office, risk management and quality management.

**3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.**

Even though the facility management had a working understanding of the capacity of the community to provide services to increasingly complicated clients, interviews with direct care staff indicated that the majority of staff did not. Most spoke of residents that had been discharged who returned to the facility as "failures", noting that their condition was much worse than went they left. Ten of the twelve staff members interviewed indicated that the community serves mild or moderate mentally retarded clients who do not have behavioral or medical challenges. Direct care staff indicated that the community could not provide the staffing patterns necessary to assist the residents in the same manner that the facility was able to do.

Most of the staff interviewed indicated that the facility served as the safety net for the community by accepting and training individuals who could not receive the services they need within the community

**4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.**

The facility has the capacity to provide services for all ages from children to geriatric consumers. SEVTC is licensed by DMHMRSAS to provide services for children under

the age of 18. It was reported that the facility did not have any requests for respite services during the period of July 1, 2003 to July 1, 2004.

**SOUTHEASTERN VIRGINIA TRAINING CENTER**
**FINDINGS AND RECOMMENDATIONS**

**Finding 1: The majority of staff interviewed, including administrative, clinical and direct care staff, indicated that the facility did not have a formalized mission statement.**

**Recommendation: It is recommended that SEVTC develops a mission statement with broad-based staff participation and assure that the mission statement is consistent with the system-wide DMHMRSAS Vision Statement.**

> ***DMHMRSAS Response****: SEVTC's leadership staff will work the initiative undertaken within the Department's Division of Facility Management as noted within our response to the systems recommendations to assure their mission, vision and values are consistent with that of the Department. They will collaborate with the other MR Facility Directors to identify training and actions needed to assure the facility culture reflects the mission, vision and values of the Department. The target date for this initiative is June 30,2005.*

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**Finding 2: SEVTC used isolated time-out 529 times during 2004. The maximum number of times any of the other 4 training centers used this most restrictive technique during the same period was 15 times. One of the other four training centers has been able to eliminate the use of use of isolated time-out and has banned the use of the technique.**

**Recommendation: It is recommended that SEVTC take immediate steps to drastically decrease or eliminate the use of isolated time-out.**

> ***DMHMRSAS Response:*** *(See DMHMRSAS response to this recommendation within systems recommendations) The Department would also like to point out that three individuals accounted for a majority of the ITO occurrences in 2004. Program data for two of those individuals shows significant progress later in the year. In fact, during the last quarter of 2004, these two individuals had a combined total of just ten occurrences. The team at SEVTC continues to work with the third individual. Center interdisciplinary teams will review all residents with programs that include isolated time-out with a goal of decreasing use of this procedure during 2005.*
>
> *In addition, SEVTC will participate in an iniative undertaken by the Central Office Office of Health and Quality Care (OHQC) which in part will determine the reasons why SEVTC is an outlier relative to the use of isolated time out and will examine best practices in addressing challenging behaviors. A series of recommendations will be forthcoming from the work with the OHQC by*

*October 2005. SEVTC is being encouraged to obtain case consultation and technical assistance through the OHQC regarding cases with the highest use of Isolated Time out. These efforts will be on going through 2005.*

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**Finding 3: There was evidence that Building 28, in particular, and the grounds, in general were not well maintained during the time of the facility inspection.**

**Recommendation: It is recommended that SEVTC develop a specific mechanism for tracking the condition and maintenance of Building 28 as this residential unit has been and continues to be the site with numerous environment of care issues.**

***DMHMRSAS Response:*** *The Buildings and Grounds Department at SEVTC, which includes Maintenance and Housekeeping, makes routine rounds to assure that cottages and grounds are maintained appropriately. Quarterly surveys are done of staff for their input on services. The Safety Program also includes Building 28 on a rotating basis with the others in Safety Rounds looking for dangers to residents and staff. Each of these programs will focus closer attention on Building 28 and make more routine rounds of both inside and outside the building effective February 14, 2005. A Quality Management pinpoint at SEVTC will be added to the current QM Plan to monitor these activities. Works orders will be immediately generated from these rounds for any item that is broken, dirty, or a safety hazard.*

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**Finding 4: Despite the fact that each shift did have on duty the number of staff that are called for in the facility's established staffing ratio, staff deployment during certain activities observed by the OIG was not sufficient to create a treatment environment that engaged residents in training/treatment programs and met the individualized training needs of the residents in a consistent manner.**

**Recommendation: It is recommended that SEVTC review staffing patterns and deployment of staff to assure that the complement available allows for the active treatment of residents at all times.**

***DMHMRSAS Response:*** *The SEVTC Program Director and Quality Manager will evaluate staff competencies to assure active treatment is occurring in cottages. Where skill sets are deficient related to the provision of active treatment the Program Director will meet with the Training Director to identify a training plan to assure a time frame for staff to obtain training. These activities will be completed by June 30, 2005. The facility will also gradually reduce the resident census by a minimum of 8 beds in order to improve staffing ratios as agreed earlier in this year. As recommended, SEVTC will continuously review deployment of staff to assure individualized resident needs relative to supervision*

*and treatment planning and will be able to demonstrate staff redeployment based upon need at any given time.*

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**Finding 5: Space for vocational programming and other non-residential unit training activities is not adequate.**

**Recommendation: It is recommended that DMHMRSAS place the highest priority on adding additional facility space for vocational programming and other non-residential unit training activities.**

***DMHMRSAS Response:*** *SEVTC's residents and staff would benefit from additional space tailored for vocational training and employment to include industrial/production workspace, materials delivery and storage space, and facilities for recycling. Significant improvements of this nature are difficult given current fiscal limitations. SEVTC will seek ways of improving the utility of space currently available. This internal review will be completed by June 30th, 2005. Additionally, the Department's 2005 Capital Budget submission includes funds for renovation and construction of three new residential buildings. Within that project space will be allocated for vocational programming. The Capital submission will be forwarded to the Governor by June of 2005.*

**CENTRAL VIRGINIA TRAINING CENTER**
**September 9-10, 2004**
**OIG Report#104-04**

**INTRODUCTION:** The Office of the Inspector General (OIG) conducted a primary inspection at Central Virginia Training Center in Lynchburg, Virginia during September 9-10, 2004. The inspection focused on a review of the facility through the application of thirty-two (32) quality statements divided over five (5) domains. The domains include: missions and values, access, service provision, facility operations and community relationships. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the five training center facility directors, parents and advocacy groups, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Retardation Services staff and directors of mental retardation services for community services boards. The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. This report is divided into five primary sections focusing on each of the domains.

**SOURCES OF INFORMATION:** Interviews were conducted with twenty-seven (27) members of the staff including administrative, clinical and direct care staff. Documentation reviews included, but were not limited to: four (4) clinical records, approved behavioral plans, selected policies and procedures, staff training curriculums, facility quality management plans, survey materials and performance improvement initiatives.

## MISSION AND VALUES:

**1. The facility has a clear mission statement.**

Interviews were completed with twenty-seven (27) members of the staff including administrative, clinical and direct care staff. At the time of the inspection, administrative staff indicated that the facility did not have a formally defined mission statement but identified this as a project that the new facility director wants to undertake during this fiscal year. Staff notified the OIG at a later time that an outdated facility mission statement had been discovered and would serve as the foundation for their planned review.

All of the staff members interviewed had a working knowledge of elements that would define the facility's mission. The most frequently presented elements included the following: to provide quality services to the residents, to address each resident's individual needs through person-centered planning, to provide a safe environment and to assure that services are provided by a well trained competent workforce.

**2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.**

Of the twenty (20) staff members asked to address this quality statement, all indicated that the facility operates from the principle of treating each individual with dignity and respect. Most (17) related that when the staff treat each other this way the value extends to the manner in which the staff treat the residents. Other values identified included honesty, integrity, professionalism and equality of treatment. Interviews revealed that the facility has an extensive staff-mentoring program. One of the goals of this program is for seasoned staff to be paired with newly hired staff so that the more experienced staff can model appropriate interactions between the staff and the residents while assisting the new staff in understanding the expectations regarding their position. The staff picnic was identified as a way of letting staff know that they are valued and that they play a valuable role in the quality of services provided.

## ACCESS/ADMISSIONS

**1. Policies and Procedures that govern admission are consistent with the facility's mission statement.**

The OIG could not make a determination regarding this quality statement, as the facility did not present the team with a formalized mission statement at the time of the inspection.

**2. Admission to the facility is based on a thorough assessment of each applicant's needs and level of functioning.**

Interviews with seven (7) administrative and supervisory staff members, a review of four resident records, and a review of facility policy revealed that the facility's admission process is based on a thorough assessment of each applicant's needs and level of functioning.

A committee at the facility designed to assure that the facility is both the least restrictive alternative and the best setting for addressing a person's needs screens each potential applicant. As with the other training centers, CVTC has a well-defined admissions process. This involves a thorough review of the information forwarded by the community services board regarding the applicant's status and need for services. Interviews indicated that the community assessments conducted and submitted as a part of the admission process include, but are not limited to:

- Current medical status including immunization history and psychiatric evaluation
- Psychological assessment (less than 3 yrs old)
- Social history
- Individualized Educational Plan (IEP) for those ages 2 through 21
- Vocational evaluation (if in a community day program)
- Prescreening Report (including identification that no less restrictive alternative exists, training recommendations and discharge plans)

Once the applicant is admitted to the facility, a registered nurse (RN) reviews the referral information record and conducts an initial assessment, including identifying areas of risk such as falls. The resident receives a full physical within 24 hours of admission. Other disciplines such as psychology, social work, occupational therapy and physical therapy complete individualized assessments of the resident in preparation for completing the resident's individualized habilitation plan (IHP). The expectation is that the IHP be completed within thirty days of the admission. Throughout this process, observations are made of the resident's adjustment to the facility. In addition, communication is maintained with the resident's legally authorized representative during this initial period as well to keep them informed of the resident's progress. Through the use of observation and communication with the resident, the facility assures that the goals and objectives that are developed are based on the resident's preferences and needs.

There have been two (2) planned admissions to the facility during the period of 7/1/03 to 7/1/04.

**3. The facility has a mechanism in place for addressing emergency admissions.**

Interviews revealed that emergency admissions are handled in the same manner as those seeking regular admissions. It was reported that the facility receives between three to five requests each month for emergency admission but less result in a formal application for admission. When there is a request for an emergency admission, the facility first reviews possible ways of aiding the person through the development of additional supports so that he/she will be able to remain in the community. Facility staff are available to provide the consultation necessary to support this goal. Interviews revealed that this intervention has been successful in reducing the number of emergency admissions. After completing the necessary assessments, if it is determined that emergency admission is the best alternative for the person, it is the goal of the facility to facilitate discharge back into the community as soon as possible with twenty-one (21) days being the targeted timeframe. After this time period, the facility, in conjunction with the community services board, reviews whether the person needs longer-term care or regular admission. The facility reported that during the last fiscal year there had been twelve requests for emergency admissions of which six resulted in admission.

## SERVICE PROVISION / CONSUMER ACTIVITIES

**1. Activities are designed to facilitate socialization, skills acquisition and community integration.**

Four resident records were reviewed. All provided evidence that the individualized habilitation plans were designed to address skills acquisition, facilitate socialization and provide opportunities for community integration.

Training programs with residents from Rapidan Park and Bannister were observed. Four staff members were interviewed. They demonstrated knowledge of each resident's goals and objectives. There was a wide range of activities including story telling, crafts, music,

and movement. Staff were engaged with each resident and were observed treating them with dignity and respect. Staff were noted to address the resident and ask for permission to share their goals with the inspection team. Staff made a point of introducing the residents and including them in the conversation.

The team observed two residents involved in physical therapy. The therapist worked with one individual while a physical therapy aide was assisting the other resident. The residents appeared happy. There was a relaxed, easy interaction between the residents and the staff.

**2. Residents are actively engaged.**

Observations in a variety of programming settings revealed that the residents are actively engaged. For example, the team observed one group participating in a craft activity. Staff explained that even though there was a defined activity occurring, the goal of the group varied for each resident. Some were working on developing their fine motor skills, others on increased attention span. The goal for one resident was to remain engaged in the activity for a defined period of time. Staff were supporting each resident in addressing his/her goal(s) throughout the activity.

**3. Activities occur as scheduled.**

Interviews and observations revealed that the activities were occurring as scheduled. Activities for a majority of the residents were occurring on their living units instead of at the normal day program setting because there was a severe storm warning in effect. Staff explained that it was decided to have the residents remain on the units because of the potential risks associated with the warning.

Several units were scheduled for an overnight outing at the campground on campus. It was indicated that because this is an activity enjoyed by both the residents and staff, the unit intended to proceed with the outing. Staff reported that every effort would be made to complete the scheduled campground activities but that this was contingent upon the weather.

**4. Residents are supported in participating in off-grounds activities.**

Interviews with staff revealed that the residents have opportunities to participate in individual and small group activities in the community such as going shopping, going to the local parks, to the zoo, movies and other recreational activities.

**5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.**

Interviews with four members of the administrative and clinical staff indicated that discharge planning is viewed as an integral part of the overall habilitation plan for each resident. There are 15 social workers at the facility that serve as the community liaison

with the resident's legally authorized representative and community case manager. The team was informed that there were 75 residents identified for discharge. Active planning on their behalf includes having potential community providers visit the campus. This provides opportunities for both the provider and resident to interact with each other before visits into the community are arranged. Facility staff are available to assist the resident and community staff by providing transition services. Interviews revealed that the facility has a 90-day timeframe for residents to return to the facility if problems arise during the initial phases of the placement instead of the traditional 28-day timeframe. The team was informed that outreach services were less available due to limited resources.

## FACILITY OPERATIONS / SAFE ENVIRONMENT

**1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.**

Interviews revealed that the safety and security of the residents is one of the highest priorities established by this facility. This was voiced by all those interviewed from the facility director to the direct care staff. The facility has developed a number of ways for assessing and monitoring the safety and security of the residential units.

Interviews indicated that safety begins with the proper identification of all persons on campus. Each visitor is asked to sign in and is given an identification badge. Staff are trained to provide a "watchful" eye not just for unidentified persons on campus but to recognize and report any areas of potential hazard or risk. The facility has a Safety Committee that reviews all aspects of campus safety. Safety audits of the buildings are conducted at least monthly. Work orders can be forwarded to Buildings and Grounds from any department on campus. The work completed is prioritized based on its level of risk.

The Environment of Care Committee reviews areas identified with specific risks, such as falls and medication errors. Once an issue is identified, the committee develops a plan of correction and tracks the plan until it has been resolved.

The facility maintains a police force of eight, including a Chief of Police and seven certified law enforcement officers. The officers patrol the campus and conduct security checks on the buildings. The campus police have direct contact with the local fire and emergency response units. They are responsible for the grounds and a one-mile perimeter around the campus. This also includes a 12-mile jogging path that runs beside the campus. The Chief of Police works to maintain a good working relationship with both the Lynchburg and Amherst County law enforcement offices.

**2. There are adequate safeguards to protect residents from abuse and neglect.**

Interviews revealed that the safeguards for protecting the residents from abuse and neglect start at the hiring process. Background checks are conducted on all new hires. Staff training regarding human rights, abuse and neglect is included in staff orientation

for new hires and again in annual trainings. The trainings review the definitions of abuse and neglect as well as the procedures for staff reporting allegations of such.

The human rights advocate participates in a number of forums during which issues associated with the residents are discussed. One of these forums is the morning report. This is a meeting during which significant events of the previous 24-hours are reviewed and discussed, including resident injuries. In addition, the advocate reviews all allegations of abuse and neglect, and monitors the investigation process on behalf of the consumer. Allegations are reported to the facility director who forwards the allegations to the investigator for review and follow-up as appropriate. Two members of the facility's police force are primarily assigned as investigators of abuse and neglect. It was noted that these individuals do a very nice job balancing their duties within the facility and completing the investigation in a timely manner. There were 20 allegations of abuse and neglect at the facility during the first six months of 2004. Four were substantiated.

One key safeguard emphasized by those interviewed was the length of time a majority of the staff has been employed at the facility. Interviews revealed that it is not unusual to have a number of staff members in the residential units that have "grown up" with the residents over the past 15 to 25 years. Staff were described as dedicated to the residents, which was noted as a major factor in the prevention of abuse and neglect.

**3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.**

The risk manager tracks critical incidents, both those that fit the criteria for reporting to VOPA and those incidents that impact patient safety but do not result in injuries such as the number of falls and peer to peer aggression. The facility risk manager also reviews critical incidents for elements of possible abuse and neglect. Data is collected and routinely communicated with management and staff. There have been approximately 170 reported incidents at this facility from January – June 2004. There were 224 incidents of peer-to-peer aggression during this same period, 158 of these incidents resulted in injuries to one or both of the residents involved. Performance improvement teams have been designed to address issues identified through their review. Routine safety and security checks are a mechanism for identifying and addressing environmental issues that could jeopardize the well being of the residents.

The facility has a hospital on-site to provide for first line response to emergencies. There is a physician on the campus at all times. Physicians and RNs are required to maintain advanced life saving certification.

**4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.**

CVTC has not used locked or isolated time-out since the early 1980's. Protective restraints are used by the facility. Protective restraints refer to devices used to compensate for a "specific physical deficit" and are considered a restraint only when the resident does

not have the option to remove it, such as a helmet that acts as a passive barrier but can not be removed by the resident. The voluntary use of a helmet designed to protect the resident is not considered a restraint, according to those interviewed. The use of protective restraints and mechanical supports are outlined by policy. Members of the rehabilitation staff meet with the resident to conduct an evaluation and to make recommendations to the team regarding the use of protective restraints and mechanical supports. The evaluation identifies the specific needs that will be addressed by its use. A physician's order is necessary before use of the restraints can be initiated.

During the tour of Shenandoah House, staff shared that there is a chair that was used to restrain residents when their behavior presents imminent risk to themselves or others. The team was informed that use of the chair is a part of a particular resident's behavior management plan. Several staff, however, stated that the chair is used with residents without plans if the frequency of use is below an established threshold for initiating a formalized behavioral plan.

At the time of the inspection, the team was informed that the facility had 215 residents in approved protective restraints. These included the use of seatbelts, helmets, bedrails, adaptive clothing and tray boards. There were 350 residents with behavioral plans, 215 of which are classified as restrictive.

**5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.**

Human Rights training is provided for all staff at the time of their orientation and annually thereafter. Residents and their legally authorized representatives are advised of the human rights process at the time of admission and at least annually. Documentation of this is located in the resident's record.

The facility has both an informal and formal process for handling complaints. The facility director handles informal complaints, as is the procedure with the other training centers. It was noted that the facility handled 12 informal complaints and addressed 8 formal complaints during the first six months of 2004.

**6. Medication usage is appropriately managed.**

The facility has established policies and procedures for the handling of medications. Staff are appropriately trained in the use of medication management and must demonstrate competency before being able to administer them. Monitoring medication usage is completed by the pharmacy. Areas reviewed include medication errors, accountability for controlled drugs and adverse drug reactions.

Interviews revealed that the facility has placed a great deal of emphasis on the reporting of medication errors. The focus is primarily on the correction of errors and not just on disciplining the staff. Interviews indicated that as the facility has stressed learning over

discipline whenever possible, the reporting of errors has become timelier so that they can be appropriately handled.

**7. There are mechanisms to address areas of concern regarding staff safety.**

There is an expectation at the facility that staff injuries are to be reported in a timely manner. The human resources office tracks these and claims are filed, as appropriate.

The Safety Committee and Office of Risk Management address issues identified as staff safety risks. Environmental safety checks identify and correct physical conditions that could have an impact on the safety of both the staff and residents. Members of the campus police force provide for the public safety of all persons on the campus and have been utilized when issues of domestic violence or other difficulties are brought to the work setting.

## FACILITY OPERATIONS / LIVING ENVIRONMENT

**1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.**

Many of the residential units that were toured appear very institutional in spite of efforts to make the environment appear more homelike. Decorations were used to "soften" the overall stark appearance in all the residential areas. The use of pictures and other forms of decorations was primarily in the common areas. The resident bedrooms were less decorated. It was noted that the living areas in Shenandoah House were freshly painted. Curtains and other coverings are used to assure resident's privacy in all of the areas toured.

**2. The residential environment is clean, odor free and well maintained.**

Members of the OIG team conducted tours of selected units in Shenandoah Hall, Rapidan Park, and Bannister Hall. The facility was noted to be extremely clean, well maintained and odor-free.

Interviews revealed that the three most critical capital improvement projects for this facility are renovations to Building 8, Building 9 and Building 12 which involved complete renovations to meet Life / Safety Code standards including removing the pony walls and providing full height walls; installing a sprinkler system, fire alarm and smoke detection systems; and renovating the HVAC system. The capital improvement project for Building 8 was funded in the 2004-2006 biennium budget at $3 million. The renovations for Building 9 and 12 are not funded but the team was informed that funding would be requested during the 2006-2008 and 2008-2010 biennium, respectively. The projected costs for these renovations total $7 million.

There are several capital improvement projects that are currently approved and funded. These include:

- Repairing and replacing the roofs on Building 49 and Building 31 at a cost of $708, 217.
- An asbestos abatement project, which includes removing asbestos from pipes in the pipe chases and mechanical rooms, and removing floor tiles and reinsulating/retiling in selected buildings
- Building 11 renovations

The first two projects listed are currently near completion. The renovations on Building 11 are funded but bids have not been completed.

**3. There is evidence that the residents are being taken care of by the facility.**

Throughout the tours, the team had an opportunity to observe the residents. All appeared properly clothed, clean and well provided for by the facility. It was observed that staff promptly addressed any hygiene problems with the residents as they arose. The staff were supportive of the residents and were observed treating them with dignity and respect. One team member rode a bus that was transporting residents from their residential units to the day treatment activities. Staff and resident interactions were relaxed, jovial and respectful.

**4. The facility provides for access to primary health care that is coordinated and comprehensive**.

On the day of the inspection, there were 573 residents. CVTC has five (5) service centers on campus. Four (4) of the centers are certified intermediate care facilities for persons with mental retardation (ICF/MR) and one (1) center is a skilled nursing unit. In addition, the facility has an acute care center on grounds. The facility has ten (10) primary care physicians including one full-time psychiatrist. There is also one family nurse practitioner on staff. Medical care staff are assigned to the units and complete daily rounds. There is a physician on the campus at all times. After 5:00 p.m., the physician is based in the clinic.

All residents receive a comprehensive annual physical. In addition, residents have access to a number of clinic services. The facility uses Lynchburg General Hospital or the University of Virginia Hospital for special hospitalization and emergency services.

Nursing completes quarterly healthcare reviews on all of the residents, noting any changes in their healthcare status and other information regarding their physical health. The nurses have a caseload of approximately 30 residents. Two staff persons are certified emergency medical technicians.

**5. The facility has a mechanism for accountability of resident's money.**

There is a patient accounts division under the facility's fiscal office. Interviews with staff indicated that it is the qualified mental retardation professional (QMRP) that has the final responsibility for keeping track of the resident's funds. Requests for needed items are submitted to the QMRP who authorizes the transactions. Staff that assist the residents in making the necessary purchases are required to submit a receipt.

## FACILITY OPERATIONS / STAFFING PATTERNS

**1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.**

Interviews with management indicated that the facility employs sufficient qualified staff to address the supervision and treatment needs of the residents. Facility management is currently reviewing how the facility is deploying its direct care staff to determine whether its current staffing patterns are the most effective use of the available personnel. The facility employs approximately 1,500 personnel of which 798 are direct care workers, nursing staff and special activities aides. The team was informed that each center is responsible for deploying staff within its units. Staff may be asked to work in any area in their assigned center depending on need such as when residents are on a 1:1 status or there are staff absent due to illness or vacations. The direct care staff reported that there was adequate staffing but maintained that the numbers required for addressing the needs of the residents are secured through an extensive use of overtime.

Four units in the Shenandoah House were toured. One unit housed 7 residents and had 4 staff persons. The remaining units had up to 12 residents and 5 staff members present. The team visited two units in Bannister. Both units had 12 residents and 3 staff members present.

**2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of resident supports and care.**

Interviews indicated that the turnover rate for the facility is relatively low. The rate is the second lowest of all of the state training centers. The team was informed that the average number of years of service for the employees is fifteen (15) years. Many of those interviewed during this inspection reported being employed by the facility for 25 to 30 years.

Overtime usage at the facility is extensive due primarily to the number of call-ins, the acuity level of the residents and an increase in the use of 1:1. Overtime is one factor that is being examined as management reviews the effective deployment of staff. Interviews with direct care staff cited overtime as the primary source of work frustration and dissatisfaction.

**3. Direct care staff possesses the competencies necessary for providing services.**

Interviews with training and supervisory staff, as well as a review of the training materials revealed that the majority of critical tasks for direct care staff are based on competency reviews, which involved either tests or demonstrations. Interviews revealed that as most of the supervisory staff tend to be long-term employees and are well-versed in the issues that the direct care staff are facing.

## FACILITY OPERATIONS / SYSTEM PERFORMANCE

**1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.**

Data collection is used to support and enhance facility performance in a number of areas. Staff training data is maintained and reported to the facility risk manager on a monthly basis to assure that all staff are compliant with the required training. Performance evaluations are tracked for additional training needs.

The Office of Information Technology (IT) has been effectively used to assist the occupational therapists and speech therapists in using digital pictures for demonstrating the proper positioning and adaptive equipment used for the nutritional management of the residents.

It was indicated that the administration is very supportive of enhancing the facility's ability to upgrade its systems in order to provide additional support of the various services and programs. However, with limited resources, the administration is often forced to choose between additional computers and replacing a broken dishwasher. Those interviewed related that it is understandable that the facility will prioritize funding that which has the greatest impact on the residents.

**2. There is a system for continuous quality improvement.**

Interviews revealed that the facility has initiated a number of successful quality improvement projects designed to enhance the quality of services for the residents. One such example is a performance improvement project that assures that the food served each resident is of the consistency needed, served at an appropriate temperature and appropriate to his or her nutritional needs. Interviews revealed that the new facility director has, in cooperation with senior management, developed a process for increasing quality assurance initiatives within the facility.

**3. Residents and other stakeholders have an active role in program development and quality improvement activities.**

Interviews revealed that families have not been formally involved in program development and quality improvement activities within the facility but indicated that a

number of families have actively advocated for the residents. They have worked with the facility in crafting programs designed to meet the needs of all of the residents.

## COMMUNITY RELATIONSHIPS

**1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in its catchment area.**

One of the goals established by the new facility director is to understand and strengthen wherever possible the working relationships that the facility has with agencies within the community. The facility has initiated the establishment of regular and ongoing meetings with the primary community services boards served by CVTC. Most of the work to-date occurs in the context of interactions resulting from services provided to the residents through admissions, discharges and outreach.

**2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders:**

**a. With Community Services Boards**

Even though no formalized surveys have been conducted with the community services boards, the facility has initiated the establishment of regular and ongoing meetings.

**b. With parents and/or legally authorized representatives**

The facility conducted a satisfaction survey with parents and/or legal guardians three years ago. It was reported that the DMHMRSAS Central Office conducted a survey last year but interviews indicated that the facility was not provided with feedback on the results. Those interviewed indicated that the facility values the comments of family and believes it is vital to the organization to keep the residents, families and other stakeholders involved and informed.

**c. With the DMHMRSAS Central Office**

Although interviews indicated that there was not a formal mechanism established with Central Office management for obtaining feedback regarding the facility's performance, staff outlined several ways in which the facility is able to interface with the Central Office. These include the facility directors meetings, the medical directors meetings, and on-going contact with the DMHMRSAS IT Department and the Office of Risk Management. The facility director indicated that Central Office staff have actively provided support to assist her in becoming more familiar with the workings of the mental retardation service delivery system.

Interviews revealed that a recent unannounced visit by Secretary Woods to the facility was very welcomed because it highlighted for facility personnel that she valued the role the facility serves in the delivery of services to persons with mental retardation.

**3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.**

Because a number of the staff interviewed have been employed by the facility for an extended period of time, they provided a longitudinal perspective on the capacity of the community to provide services to persons traditionally served by the facility. Most indicated that over the past ten to fifteen years there has been a concerted effort by both the facility and the community to identify and facilitate residents having the opportunity to reside in the least restrictive setting possible. Although the majority of staff interviewed indicated a belief that all residents could reside in the community with the proper supports, it was still felt that the facility was currently the best-equipped provider of care for individuals with challenging maladaptive behaviors and complicated medical conditions.

Fourteen staff members were asked about the facility's role. All indicated a belief that the facility has a unique role to play in the delivery of services, particularly since CVTC is the only training center that offers intermediate, skilled and acute services. Interviews indicated that the staff have a wealth of expertise that could be a valuable resources for the community in order to maximize success for all consumers.

Seven of the staff interviewed indicated that with the arrival of a new director the facility has an opportunity to take a fresh look at itself and re-examine its mission. They felt this was a good opportunity for staff to be able to examine both the value the facility has in serving its residents and in addressing the needs of the community as well.

**4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.**

It was indicated that the facility did not have any requests for respite services during the period of July 1, 2003 through July 1, 2004. CVTC has residents under the age of 18 but these individuals are housed in the skilled care unit, which is certified by Medicare.

**CENTRALVIRGINIA TRAINING CENTER**
**FINDINGS AND RECOMMENDATIONS**

**Finding 1: The majority of staff interviewed indicated that the facility did not have a formalized mission statement.**

**Recommendation: It is recommended that CVTC develops a mission statement with broad-based staff participation and assure that the mission statement is consistent with the system-wide DMHMRSAS Vision Statement.**

*DMHMRSAS Response: CVTC has begun the strategic planning process initiated by the Facility Director with all Departments and levels of staff to gain input and agreement on what CVTC's mission, vision and value statement should look like. This process began in December 2004 and drafts are presently being formulated.*

*In addition, the facility will work with the initiative undertaken within the Department's division of Facility Management as noted within our response to the systems recommendation. (See Systems Recommendations 1 and 2.) They will collaborate with the other Mental Retardation Facility Directors to identify training and actions needed to assure the facilit8y culture reflects the mission and vision of the Department. Target date for completion of this initiative is June 30, 2005*

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**Finding 2: A majority of the residents at CVTC have been diagnosed with mental retardation, unspecified.**

**Recommendation: It is recommended that the facility review the current diagnosis of its residents to determine if a level of functioning and severity of mental retardation can be determined.**

*DMHMRSAS Response: CVTC has begun a process of reevaluation of the mental retardation diagnoses documented in the medical records. This is done through the ID Team process with the psychologist, psychiatrist and other IDTeam members input into the evaluations, thus this will take a full IHP cycle to complete all individuals who live at CVTC. An estimated target date of completion would be October 2005.*

**SOUTHWESTERN VIRGINIA TRAINING CENTER**
**October 8-9, 2004**
**OIG Report#105-04**

**INTRODUCTION:** The Office of the Inspector General (OIG) conducted a primary inspection at Southwestern Virginia Training Center in Hillsville, Virginia during October 8-9, 2004. The inspection focused on a review of the facility through the application of thirty-two (32) quality statements divided over five (5) domains. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the five training center facility directors, parents and advocacy groups, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Retardation Services staff and directors of mental retardation services for community services boards. The quality statements address the facility's mission and values, access to services, service provision, facility operations and community relationships. The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into five primary sections focusing on each of the domains.

**SOURCES OF INFORMATION:** Interviews were conducted with thirty-one (31) members of the staff including administrative, clinical and direct care staff. Documentation review included, but were not limited to: four (4) clinical records, individualized habilitation plans and behavioral support plans, selected policies and procedures, staff training curriculums, facility quality management plans, survey materials and performance improvement initiatives. Tours were conducted in selected residential and programming areas.

## MISSION AND VALUES

**1. The facility has a clear mission statement.**

Interviews were completed with thirty-one (31) members of the staff including administrative, clinical and direct care staff. Administrative staff revealed that the facility's Quality Improvement Council conducted its annual review of the facility's goals during the Summer 2004. The Quality Improvement Council used the DMHMRSAS vision statement as the foundation for revising the facility's vision statement. The facility director emphasized the new vision statement in a recent employee newsletter asking all employees to reflect on the recent changes and provide input on ways to effectively address the goals and objectives established. Staff interviewed were well versed in the new vision statement.

The mission statement for the facility is "to provide the best possible residential and habilitative service for citizens of southwest Virginia with mental retardation". Other staff comments regarding the facility's mission included these statements: to meet the service needs of the developmentally disabled; to assist residents gain the necessary skills to reside in a less restrictive environment; and to assure that the residents are healthy, safe and receive the services necessary for them to lead productive and meaningful lives.

**2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.**

The majority (28) of the staff members interviewed indicated that the facility applies the "Golden Rule" in guiding the staff in understanding the values associated with carrying out their duties and relating to others in the environment. It was indicated that staff throughout their pre-service training and in the day-to-day operations of the facility are reminded of the importance of treating each person with dignity and respect. One other value emphasized, according to those interviewed, is that the residents come first. During the tours of the facility, staff were observed relating to the residents in a relaxed, respectful and friendly manner. Staff spoke with pride regarding the residents and, as appropriate, included them in the discussions.

Nine (9) of the staff members interviewed indicated that there is a sense of family within the facility. They related that the facility director visits the units daily, asking how things are going and being open for suggestions, comments or concerns. They indicated that they are always amazed that he knows each resident and each staff member by name.

## ACCESS/ADMISSIONS:

**1. Policies and Procedures that govern admission are consistent with the facility's mission statement.**

The team reviewed the facility's policy (SWVTC Instruction 410) regarding admissions and found it consistent with the facility's mission statement. The policy outlines the process for securing the necessary information from the community for determining whether the facility is the best setting for meeting the identified needs of the applicant. Staff indicated that it has always been the approach of SWVTC to ask, "Why would we not take this person instead of why would we." It was suggested that this subtle shift in perspective required staff to focus more on how the admission would affect the person instead of how it would affect the facility.

**2. Admission to the facility is based on a thorough assessment of each resident's needs and level of functioning.**

Interviews with five administrative and clinical staff members, a review of four resident records, and review of facility policy revealed that the facility's admission process is based on a thorough assessment of each applicant's needs and level of functioning.

Each potential applicant submits an admission packet through the referring community services board. It is the responsibility of the Community Services Director at the facility to assure that an appropriate team of facility staff reviews the packet of information. Facility social workers conduct home visits in order to gain additional information regarding the applicant and to serve as a resource for families or other responsible

persons during this time of transition. The assigned social worker makes a case presentation to the Admissions Committee, which makes recommendations to the director. The director then has thirty days by which to relay the decision to the applicant and the CSB. Interviews revealed that once the person is admitted to the facility, initial assessments are conducted in order to begin the process of developing the person's individualized habilitation plan.

Nine scheduled admissions were completed at this facility during the period from 7/1/03 to 7/1/04. The team was informed that an additional five people were accepted for admissions but they are currently on a waiting list for an available bed.

The admission process to the Pathways Program is the same except a regional board makes the final determination regarding admissions to that program, not just the facility director. This regional program is designed to address the often-challenging training and behavioral issues of the dually diagnosed (MH/MR) population.

**3. The facility has a mechanism in place for addressing emergency admissions.**

Interviews revealed that emergency admissions are handled in the same manner as those seeking regular admissions but that the facility does not require all of the community assessments to have been completed prior to review of the case. This is because of the emergent nature of the requests. Basic information regarding the person's status, including any medical and behavioral healthcare needs, is required prior to admission. The facility also reviews possible ways of aiding the person to remain in the community through the development of additional supports. Facility staff are available to provide the consultation necessary to support this goal. During the last fiscal year there were 26 requests for emergency admission and 3 of those were admitted. Interviews revealed that SWVTC makes every effort to assist the community with their consumers during times of emergencies. It was indicated that the facility received a number of requests from community providers outside of the region for emergency admission to the dually diagnosed (MR/MI) program on campus but that admission to that service has been limited to persons within the region.

## SERVICE PROVISION / CONSUMER ACTIVITIES

**1. Activities are designed to facilitate socialization, skills acquisition and community integration.**

Four (4) resident records were reviewed. All provided evidence that the individualized habilitation plans were designed to address skills acquisition, facilitate socialization and provide for opportunities for community integration.

During the inspection, the team observed active day programming, prevocational programming and vocational services. In the vocational programming in Building 10 there were eight residents present with one staff and a regular volunteer. The work being performed included: paper shredding, crushing cans, and the washing and drying of a

variety of items. The space was functional and appropriate for the work being completed. It was noted that the interaction between the staff and residents was very positive. Staff encouraged and supported the residents in accomplishing their tasks.

In the prevocational classroom within the same building, there were 8 residents and 2 staff members. The staff were assisting the residents in staying focused and on task. All but one resident was actively engaged. The tasks were designed to assist the residents in sorting and matching shapes.

Observations were also made of the scheduled active day programming located in the gym. Residents were engaged in a number of activities including a music group, a speech therapy group, recreational activities and sensory stimulation opportunities.

**2. Residents are actively engaged.**

Overall observations and interviews revealed that staff actively engaged the residents in the programming. The facility offers a full array of activities for residents to engage in throughout the day and early evening.

During the morning tours of several of the cottages, it was noted that the residents were preparing for the day. They were having breakfast, attending to their activities of daily living and engaging with staff. One cottage has a "walking" group that makes strolling around the campus a part of the morning routine. Three residents in that unit specifically approached the team member to indicate that they really enjoyed this activity.

**3. Activities occur as scheduled.**

Interviews and observations revealed that the activities were occurring as scheduled. Activities were occurring as planned in both the day programming areas and on the residential units.

**4. Residents are supported in participating in off-grounds activities.**

Interviews with staff revealed that the residents have many opportunities to participate in individual and small group activities in the community such as going shopping, to ball games, on picnics and to the movies.

**5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.**

Interviews with four members of the administrative and clinical staff indicated that transition planning begins at the time of admission. Most of the coordination with community placement is completed by the five (5) social workers. The social workers are not assigned a particular caseload but rather are assigned to specific community services boards. This approach has served to foster good working relationships between the

facility and the referring boards. The facility assists the residents in making as smooth a transition as possible through frequent trial visits and staff to staff interactions.

## FACILITY OPERATIONS / SAFE ENVIRONMENT

**1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.**

Interviews revealed that the safety and security of the residents is considered one of the most important functions of the facility. As a result there are a number of safety and security measures in place. Buildings and Grounds staff conduct monthly safety inspections in all of the buildings. This is coupled with routine inspections completed in each residential area by the unit manager. Unit staff interviewed indicated that the staff in buildings and grounds are very responsive when called regarding anything that needs to be fixed within the facility. All indicated that work orders that pose a safety risk to either staff or residents are prioritized.

In addition, the facility conducts routine fire and medical emergency drills. Fire drills are done monthly so that one is completed on each shift quarterly. As weather permits, residents are evacuated during the drills so that the facility has an accurate assessment of the time it would take to successfully vacate the buildings.

SWVTC has five safety and security officers who provide around the clock security services on campus. The officers patrol the campus and conduct security checks on the buildings, particularly during the evening and nighttime shifts. The officers also help with transporting residents in the evening as appropriate.

**2. There are adequate safeguards to protect residents from abuse and neglect.**

Interviews revealed that the safeguards for protecting the residents from abuse and neglect start at the hiring process with the initiation of background checks. Staff are introduced to human rights and the procedures for reporting abuse and neglect during their initial pre-service training. Staff are provided with case scenarios for discussion to assure that they are able to apply the principles and procedures they are learning. Annual re-training for both human rights and reporting abuse and neglect is required.

Staff (10 interviewed) indicated that one of the safeguards for protecting the residents is the awareness that supervisory staff and/or the facility director could enter any unit at anytime, including the evenings and the weekends. The direct care staff interviewed indicated that because of the length of time most staff have worked at the facility that they consider the residents “members of the family”. As such, they related that they would not hesitate to contact the facility director if they witnessed the abuse of a resident.

Another mechanism identified was the event reporting system, which allows for an administrative review of an incident that is unexplained or suspicious without the presence of a specific allegation. Interviews with administrative staff indicated that it is

the goal of the facility to conduct investigations in such a manner as to maximize the learning opportunities for the staff instead of it being a "gotcha" process. Two members of the facility's police force are trained abuse and neglect investigators. All those interviewed indicated that they had confidence that the investigators would perform their duties in a confidential and professional manner. There were 44 allegations of abuse and neglect made at this facility during the first six months of 2004. None of the allegations were substantiated.

**3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.**

The risk manager tracks critical incidents. There were approximately 40 critical incidents reported to VOPA and the OIG from January to September 2004. Each of these are reviewed by the facility director, human rights advocate and quality assurance officer within the facility. The risk manger looks for trends in the data by conducting routine reviews to determine not only what events are occurring but also when and where the events take place. For example, in reviewing the incidents reports it was noted that there had been several injuries to residents on the swings. This information was communicated to buildings and grounds staff, who conducted safety checks on all the swings on campus. It was noted during the checks that several of the swing chains had become loosened due to their frequent usage, which could result in scratches, catching the resident's clothing or potential falls due to breakage. Maintenance staff replaced the chains with heavier ones that had additional safety latches to prevent possible risk to the residents.

The risk management and residents safety committees also review the aggregate data during their regularly scheduled meetings. When concerns are identified, plans of action are developed and followed until resolved. There were 160 incidents of peer-to-peer aggression reported at the facility during the first two quarters of 2004. Eighty-two of the incidents resulted in minor injuries to one or both of the residents involved. In each case, strategies were developed to lessen the likelihood of a reoccurrence.

Interviews with medical and nursing personnel revealed that the facility's on-going and routine review of the residents' healthcare status is an additional safeguard for protecting the residents from critical and/or life threatening events. The facility completes many preventative health checks on the residents. It was also noted that staff, in general, serve to protect the residents from life threatening incidents. It was reported that staff feel comfortable reporting any concerns regarding a resident to either the medical director or nurse practitioner.

**4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.**

Interviews with 12 administrative and direct care staff, a review of 2 records with behavioral plans and a review of the behavioral management policy (SWVTC Instruction 570) indicated that the facility implements restrictive procedures in accordance with the policy.

As with the other facilities in the state system, staff are trained in the Therapeutic Options for Virginia (TOVA) model, which focuses on developing effective working relationships. It also provides staff with a greater understanding on how to effectively apply behavioral management strategies. Interviews with supervisory staff revealed that a large percentage of the direct care staff have indicated that this approach is easier to understand and better than previously used training materials. One of the goals of the TOVA training, according to direct care staff, is the reduction of behavioral management plans that have restrictive procedures. The facility data indicated that there are approximately 160 residents with behavioral management plans, 54 of which involve procedures that require approval by the local human rights committee. The facility tracks the use of restrictive procedures and uses the information for case review, as well as for providing additional training opportunities when appropriate.

SWVTC currently has less than five individuals with a behavioral management plan that has isolated time-out as an approved intervention. However, administrative staff related that this technique is almost never used even when it is an option.

Isolated timeout is defined as "the removal of a client from ongoing reinforcement to a specifically designated time-out room." SWVTC complies with CMS regulations, which outline the circumstances under which ICF/MR facilities can use the time-out room. These include:

- The use of the time-out room has to be a part of an approved systemic time-out program.
- The use of the time-out room can not be used as an emergency intervention,
- The client is under direct constant visual supervision while in the time-out room
- The door to the time out room is held shut by staff or by a mechanism requiring pressure from staff

**5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.**

Human Rights training is provided for all staff at the time of their orientation and annually thereafter. Residents and their legally authorized representatives are advised of the human rights process at the time of admission and at least annually. Documentation of this is located in the resident's record.

The facility has both an informal and formal process for handling complaints. The facility director handles informal complaints, as is the procedure with the other training centers. It was noted that the facility handled 9 informal complaints and addressed 9 formal complaints during the first six months of 2004.

Notifications of the resident's rights and the complaint process were located in the resident records reviewed.

**6. Medication usage is appropriately managed.**

SWVTC has written protocols for the handling of medications. Nursing personnel indicated that the facility fosters a teaching environment, which enables staff to feel comfortable in addressing any area where they might need additional instruction. Medication errors are reported and tracked both by the Director of Nursing and the Pharmacy and Therapeutics Committee.

Medication usage is monitored by the prescribing physicians for potential side effects and/or reactions. The medical staff stay informed about new medications by consistently reviewing the literature and guidelines. It was indicated that even though this is often a time-consuming process, it fosters a sense of confidence that their actions contain a reasonable expectation for having the greatest positive impact. Staff are appropriately trained in the use of medication management and must demonstrate competency before being able to administer the medications.

The medications are stored in a room under a double-lock. Medications are checked against the physician's order and the medication administration record before they are dispensed or administered.

**7. There are mechanisms to address areas of concern regarding staff safety.**

Interviews with administrative staff indicated that the facility does have a mechanism for addressing staff safety. There is an expectation at the facility that staff injuries are to be reported in a timely manner. The Human Resources Office tracks these and claims are filed, as appropriate.

The Safety/Health Committee addresses workplace safety. Issues addressed by this committee include staff injuries, the maintenance and safety of equipment used by staff in executing their duties, and campus-wide security issues. Environmental safety checks identify and correct physical conditions that would have an impact on the safety of both the staff and consumer.

The team was informed that the accident rates on the campus are very low. The highest injury rate is associated with the aggressive behavior of the residents.

## FACILITY OPERATIONS / LIVING ENVIRONMENT

**1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.**

There was evidence that the residents are provided with opportunities to personalize their rooms. In Cottage 5C, it was noted that several of the walls in each bedroom were painted a rich color like deep blue or green which gave rooms a comfortable inviting feel. Curtains or other window coverings were used to afford the residents privacy.

**2. The residential environment is clean, odor free and well maintained.**

Members of the OIG team conducted tours of selected residential units on campus, including Cottages 5C, 6B, 8C, the Pathways Cottage and a unit in Building 3. These buildings were noted to be clean, well maintained and odor-free. Furniture in the living areas appeared comfortable and well maintained. No broken or torn areas in the fabric were noted. Inviting colorful pictures/posters were on the walls. The use of stencils helped make the walls look less stark and institutional. Efforts to make these settings seem more home-like extended into the yard. Small patios with furniture, swings and hammocks were available for the residents' enjoyment.

The overall campus is very well maintained. The grounds had been recently mowed. Sidewalks and around the foundation of the buildings showed evidence of recent edging of the grass. Flowerbeds were generally well maintained. Play equipment was very well maintained.

A member of the review team had an opportunity to talk with several Building and Grounds staff and was impressed with their dedication and appreciation for the needs of the residents. All appeared to take real pride in the appearance of the campus and to understand the importance of assuring the safety of the residents.

The following capital improvement projects were identified as currently approved and funded:

- The replacement of roofing on all buildings, particularly those with shingled roofs
- The replacement of HVAC units on Buildings 1,2,9,10 and the cottages
- The replacement of the existing freezers/coolers and the construction of an additional freezer in Building 2 Food Service area.
- The replacement of the underground heat distribution lines

Administrative staff were asked to identify three of the most critical capital improvement projects that need to be addressed at the facility. Their response included:

- The renovation of the 14 cottages in order to provide better handicap access, storage, and activity space. These renovations include the replacement of the HVAC units.
- The construction of an enclosed area around the Building 3 patio.
- Obtaining an emergency generator to power the 14 cottages and Buildings 1,2,9, and 10

**3. There is evidence that the residents are being taken care of by the facility.**

Throughout the tours, the team had an opportunity to observe the residents. All appeared properly clothed, clean and well provided for by the facility. It was observed that staff promptly addressed any hygiene problems as they occurred.

The staff were observed treating the residents with dignity and respect. The manner in which staff interacted with the residents was supportive, positive and warm. The residents seemed happy.

In the Pathways Cottage, staff introduced the residents and included them in the conversation, when appropriate. Staff and resident interactions were relaxed, good-humored and respectful. Staff reported how proud they felt of the residents and the strides they had made. It was apparent by the residents' reactions that these comments were meaningful to them.

**4. The facility provides for access to primary health care that is coordinated and comprehensive**.

On the day of the inspection, there were 217 residents. SWVTC's medical director is the facility's primary care physician. The facility also has a family nurse practitioner and a psychiatrist. All residents received a comprehensive annual physical. The facility maintains an infirmary that serves residents with routine medical conditions that need closer monitoring. The facility has an on-call system for addressing medical concerns after 5:00 pm. Nursing personnel indicated that there is an excellent on-call physician response time to the calls, usually less than five minutes. Interviews revealed that nurses are empowered to initiate appropriate interventions for the residents in emergency situations.

The medical director maintains a good working relationship with the local hospital. This fosters a trust between the facility and the community provider that facilitates the residents receiving timely community-based healthcare. Residents have access to a number of other services such as dental, ophthalmology, and neurology.

Nursing staff complete quarterly healthcare reviews on all of the residents, noting any changes in their healthcare status and other significant information regarding their physical health.

**5. The facility has a mechanism for accountability of resident's money.**

Interviews with staff indicated that the facility has an established procedure for the accountability of resident's money. Staff that assist the residents in making the necessary purchases are required to submit a receipt.

## FACILITY OPERATIONS / STAFFING PATTERNS

**1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.**

Interviews were conducted with administrative and direct care staff. All those interviewed related that the facility maintains a sufficiently qualified staff to address the supervision and safety needs of the residents. Both management and clinical staff

indicated that it is often challenging for the facility to maintain adequate professional staff to assure the training needs of the residents. For example, the facility has been recruiting for a licensed physical therapy assistant and 2 RNs for approximately three months. One explanation offered was that the facility is not able to offer a competitive salary in many of these positions.

Many of the recent applicants for direct care staff positions are individuals who were displaced by the loss of manufacturing positions in the area. For the most part, interviews indicated that these individuals make excellent employees because of their good work ethic and willingness to participate in the training necessary to obtain the skills needed to effectively complete their duties. All those interviewed indicated that the average salary for the direct care staff should be increased in order for the facility to maintain an adequate workforce.

Staffing patterns in the residential areas included the following:

- In the cottages there were 2 direct services associates (DSA) during the day shift for the 8-10 residents, 1 DSA and 1 active treatment supervisor on the 2nd shift and 1 DSA on the 3rd shift
- In one of the units in Building 3, there were 4 staff members present for 18 residents.

**2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of resident supports and care.**

Interviews indicated that the turnover rate for the facility is relatively low, currently around 6%. SWVTC has the lowest rate of turnover for all of the training centers, however, the facility has experienced an increase in turnover for the past several years.

Overtime usage at the facility continues to be an issue, but the facility has made some significant reduction in this since 2002. One of the contributing factors to the use of overtime is the Virginia Disability and Sickness Program, which enables persons on probation to go out on short-term disability. At the time of the inspection, there were 15 people out. The average length of absence from the facility as a result of the short term disability program, is 55 days. Interviews with direct care staff indicated that the most frustrating issue for them is their inability to take off accrued leave. Five of those interviewed reported having an excessive number of accrued hours. They have difficulty obtaining approval for vacation time because there is not enough staff to provide adequate coverage if the time is taken. This was also identified as a significant problem by administrative staff.

**3. Direct care staff possesses the competencies necessary for providing services.**

Interviews with training and supervisory staff as well as a review of the training materials revealed that the majority of critical tasks for direct care staff are based on competency reviews, which involved either tests or demonstrations. Staff have the ability to participate in a number of training opportunities.

Interviews with direct care staff revealed that they believe the facility provides them with the training necessary to feel confident in performing their duties.

## FACILITY OPERATIONS / SYSTEM PERFORMANCE

**1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.**

Data collection is used to support and enhance facility performance in a number of areas. Staff training data is maintained to assure that staff have completed the training necessary for fulfilling their duties.

Data collection is central to the work of both the quality assurance office and risk management at the facility. Both review critical indicators regarding the safety and treatment needs of the residents. This information, more importantly, is routinely used to develop performance improvement initiatives. One project mentioned involved the facility changing the way they purchase laundry detergent. Instead of it being purchased in packaged containers as in most households, they began purchasing it in bulk. The savings involved in making this switch allowed for the purchase of new laundry equipment. In addition, a work opportunity was developed for residents who could now divide the detergent into individual containers for use in the residential areas. They could also be paid for delivering the containers to the appropriate units. This one initiative had multiple benefits.

**2. There is a system for continuous quality improvement.**

Interviews with administrative staff and a review of the facility's quality management plan revealed that SWVTC has a system for continuous quality improvement. Interviews revealed that the facility has initiated a number of successful quality improvement projects designed specifically to enhance the quality of services for the residents. The facility monitors a number of quality indicators such as the number of hours residents are involved in work, the number of IHP meetings in which the resident and family attended, and whether residents are engaged in appropriate social activity.

**3. Consumers and other stakeholders have an active role in program development and quality improvement activities.**

Interviews revealed that families have not been formally involved in program development and quality improvement activities within the facility. It was indicated however that the facility has a very active parents organization that provides feedback regularly.

## FACILITY OPERATIONS / COMMUNITY RELATIONSHIPS

**1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in its catchment area.**

The facility is engaged in a number of activities that are designed to develop and maintain working relationships with community providers and other agencies. The facility director has been actively involved in the regional planning partnership, which has been meeting to define the needs of the region. One of the outgrowths of his participation has been the development of the Pathways Program on campus. As noted previously, the social workers and the medical director maintain regular contact with their counterparts in the community. The facility works with a number of volunteer organizations, churches and other groups that are very supportive of the work done by the facility.

The facility director has been providing leadership to staff on all levels regarding the importance of SWVTC maintaining a partnership with the community. His commitment to this is evident from the interviews with staff.

**2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders:**

**a. With Community Services Boards**

Even though no formalized surveys have been conducted with the CSBs, the facility has several mechanisms in place for receiving feedback.

**b.With parents and/or legally authorized representatives**

The facility has been doing parents satisfaction surveys for years. They did not do one last year because this was being completed by DMHMRSAS. Interviews indicated that the facility was not provided with feedback on the results of this survey by central office. Those interviewed indicated that the facility values the comments of family. It was stated that the parents' organization is very active and often provides valuable feedback to the facility.

**c. With the DMHMRSAS Central Office**

Although interviews indicated that there was not a formal mechanism established with Central Office management for obtaining feedback regarding the facilities performance, staff outlined several ways in which the facility is able to interface with the Central Office. These include the facility directors meetings, the medical directors meetings, and involvement with the Office of Risk Management. It was reported that the Commissioner has communicated his vision and goals for the system. It was also reported that the Office of Mental Retardation Services has been helpful.

Those interviewed indicated that the facility would appreciate more feedback from Central Office particularly regarding the data and other information that are routinely requested and provided.

**3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.**

Ten staff members were asked about this quality statement, including administrative, clinical and direct care staff. Those interviewed indicated that the facility has provided a vital service to the community through its thirty-year commitment to the provision of comprehensive residential, training and healthcare services to persons with mental retardation.

Staff at SWVTC voiced a belief that the facility is working in partnership with community providers to address the challenging and changing needs of this special population. This was best exemplified by the Pathways Program, which is designed to provide residential and training programs for persons from the region who are dually diagnosed. Staff in that program have experienced persons with very challenging behaviors be able to return to the community with increased skills in a relatively short period of time. This experience, as reported by several direct care staff, has broadened their beliefs that many more residents at the facility are capable of successfully residing in the community with the necessary supports. This service uses person centered planning as the framework for developing goals and strategies with the residents. Person centered planning is predicated on the belief that the person needs to be a full and respected participant in any decisions that impact his/her life. Staff in this program have had the benefit of experiencing first hand how this process works. Many indicated that it helped change their understanding of the capacity of the community to serve the same residents but at a different phase in their development.

**4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.**

Interviews revealed that SWVTC makes every effort to provide respite services when requested. It was indicated that there were often emergency requests. Respite care is designed as a program of temporary care, 21 days or less, which is needed because of a "medical or other urgent conditions of the caretaking person(s) or as a means of providing the caretaking person(s) with a needed break" (SWVTC Instruction 410). It was reported that the facility had 12 requests for respite services during the period of July 1, 2003 through July 1, 2004 and the facility was able to accommodate all of them.

**SOUTHWESTERN VIRGINIA TRAING CENTER**
**FINDINGS AND RECOMMENDATIONS**

**Finding 1: Space for vocational programming and other non-residential unit activities is not adequate.**

**Recommendation: It is recommended that DMHMRSAS place the highest priority on adding additional facility space for vocational programming and other non-residential unit activities.**

> ***DMHMRSAS Response:*** *The Department recognizes that SWVTC's residents would benefit from additional space tailored for vocational programming. Improvements of this nature are difficult given current fiscal limitations. However, the Department's 2005 Capital Proposed Budget includes funds for renovation and construction of residential buildings that will accommodate vocational programming space.*

**NORTHERN VIRGINIA TRAINING CENTER**
**October 13-14, 2004**
**OIG Report#106-04**

**INTRODUCTION:** The Office of the Inspector General (OIG) conducted a primary inspection at Northern Virginia Training Center (NVTC) in Fairfax, Virginia during October 13-14, 2004. The inspection focused on a review of the facility through the application of thirty-two (32) quality statements divided over five (5) domains. These include: mission and values, access, service provision, facility operations and community relationships. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the five training center facility directors, parents and advocacy groups, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Retardation Services staff and directors of mental retardation services for community services boards. The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into five primary sections focusing on each of the domains.

**SOURCES OF INFORMATION:** Interviews were conducted with twenty-seven (27) members of the staff including administrative, clinical and direct care staff. Documentation reviewed included, but was not limited to: four (4) clinical records, individualized habilitation plans and behavioral support plans, selected policies and procedures, staff training curriculums, facility quality management plans, survey materials and risk management reviews. Tours were conducted in selected residential areas. The OIG did not review the day treatment programs during this visit as a snapshot of the facility was completed in March 2004 during which these programs were more thoroughly reviewed. (Please refer to OIG Report #95-04 for greater detail.)

## MISSION AND VALUES

**1. The facility has a clear mission statement.**

Interviews were completed with twenty-seven (27) members of the staff including administrative, clinical and direct care staff. The facility's mission is outlined in its quality management plan. Interviews indicated that the mission plays a key role in the development of and review of services within the facility. The Center's mission is "to support the clients served so they can access a wide range of life's possibilities by fostering independence, self-esteem, and the fullest participation in family and community life."

Other staff comments regarding the facility's mission included these statements: to address the habilitation and training needs of the residents, to prepare the residents for successful participation in the least restrictive setting possible, to provide client-centered active treatment tailored to the individual needs of the residents, and to assure that the residents are healthy and safe.

**2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.**

All of the staff interviewed indicated that it was the philosophy of the facility to treat all persons, staff and residents with dignity and respect. Interviews revealed that this concept is stressed throughout the pre-service training. Direct care staff indicated that facility management stresses that the residents' needs are the center's first consideration. Staff related that supervisors and management supported them in assisting the residents in meeting their goals.

## ACCESS/ADMISSIONS

**1. Policies and Procedures that govern admission are consistent with the facility's mission statement.**

Interviews and a review of procedures demonstrated that NVTC policies and procedures that govern admission are consistent with the mission statement. The team reviewed the facility's application materials for both regular and short-term admissions. The materials indicated that the facility serves adults with mental retardation, with "sensory and physical disabilities and/or extreme maladaptive behaviors" in Fairfax, Arlington, Prince William and Loudoun Counties and the cities of Alexandria and Falls Church.

**2. Admission to the facility is based on a thorough assessment of each applicant's needs and level of functioning.**

Interviews with seven administrative and clinical staff members, a review of four resident records, and a review of facility policy revealed that the facility's admission process is based on a thorough assessment of each applicant's needs and level of functioning.

Social workers at the facility are the point of contact for persons interested in learning more about the admission process at the facility. Tours are available, with an appointment, so that prospective consumers and their legally authorized representatives can have the information necessary to make an informed decision. Once a potential applicant or his/her legally authorized representative expresses an interest in pursuing admission, the applicant is referred to the appropriate community services board (CSB). The case manager at the CSB gathers the information required for admission and submits a completed packet to the Director of Social Services for review.

The case is assigned to the social worker designated for that specific CSB who presents the case during the next scheduled Admissions Committee Meeting. Interviews indicated that the committee usually meets twice a month. The committee, which includes senior staff members, program managers and social workers, determines whether the applicant is suitable for admission. If the admission is denied, a letter is forwarded from the facility director to the CSB case manager outlining the reasons for the decision. The applicant and/or legally authorized representative have thirty days to appeal the decision.

One admission was completed at the facility during the period from 7/1/03 to 7/1/04. The team was informed that an additional 34 people have been accepted for admission, but they are currently on a waiting list for an available bed.

**3. The facility has a mechanism in place for addressing emergency admissions.**

Interviews revealed that emergency or short-term admissions are handled primarily by the facility social workers in conjunction with the CSB case managers. Ideally, when a request is received, the social worker, case manager, legally authorized representative and community liaison meet to develop an immediate plan. This plan not only addresses the suitability of admission, but can also include the facility providing additional community-based supports to help the client remain in his/her community setting. If there is a space available, the case manager works with the court to establish a certification hearing prior to acceptance. Basic information regarding the person's status, including any medical and behavioral healthcare needs, is required prior to admission. During the last fiscal year there were 4 requests for emergency admission, but the facility was unable to accommodate any of these requests.

## SERVICE PROVISION / CONSUMER ACTIVITIES

**1. Activities are designed to facilitate socialization, skills acquisition and community integration.**

Four (4) resident records were reviewed. All provided evidence that the individualized habilitation plans were designed to address skills acquisition, facilitate socialization and provide for opportunities for community integration.

During the inspection, the team observed staff assisting the residents in completing their activities of daily living in preparation for attending their day programming activities. Interviews and observation revealed that residents, who are unable to be a part of an off-grounds work program, receive services from staff on their units or they attend physical therapy at the gym, the pool, or sensory stimulation room. The team had the opportunity to observe a group of residents engaged in a scavenger hunt. Staff were relating to the residents in a relaxed yet professional manner. The residents appeared to enjoy the activity.

During the March 2004 inspection the team was informed that 86 residents at the facility were actively engaged in off-site programming. At that time, those involved in active programming on campus included 49 persons receiving unit based programming, 29 persons in the Skills Training Center (STC), 21 persons in the Developmental Day Program (DDP) and 1 resident was noted as officially in retirement.

In the STC, residents have opportunities to engage in a variety of work related activities for which they receive fair market value compensation. The activities have included: can-crushing, bulk mail stuffing, silverware rolling, managing the vending machines on

campus, and facility ground maintenance. Assignment is based on each person's level of functioning and is consistent with goals established in the treatment plan. The DDP is designed for residents that are not ready for the STC or for participating in community-based programs. Some activities that are offered in the DDP program are paper shredding and cardboard recycling.

**2. Residents are actively engaged.**

All of the residents were noted to be actively engaged by staff during the various activities observed. The facility offers a full array of activities for residents to engage in throughout the day and early evening.

During the morning tours of several of the cottages, it was noted that the residents were preparing for the day. They were having breakfast, attending to their activities of daily living and engaging with staff.

**3. Activities occur as scheduled.**

Interviews and observations revealed that the activities were occurring as scheduled.

**4. Residents are supported in participating in off-grounds activities.**

All residents have the opportunity for off-grounds activities, either through work projects or fieldtrips. Fieldtrips include going to the park, airport, mall, zoo, restaurants, local basketball games, movies, bowling, miniature golf, musical events and overnight trips.

**5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.**

Interviews with five members of the administrative and clinical staff indicated that transition planning begins during the preadmission screening phase. Discharge plans are formulated at the time of admissions and updated at least annually. Discharge is facilitated when it is determined that the client has received maximum benefit from the individualized habilitation training and is prepared for successful placement in a less restrictive environment. Interviews revealed that the social workers work very closely with the community providers to assist the residents in making a successful transition into the community. During the interviews, it was learned that one of the social workers was preparing to take two residents into the community not only to visit their prospective placement but also to gain awareness of the variety of places and activities available in the larger community surrounding the placement's location. Residents can be released on a 28-day trial visit before a formal discharge occurs. Information provided indicated that while space cannot be guaranteed, the facility makes every effort to allow discharged residents to return for up to one year if the community placement is not successful.

## FACILITY OPERATIONS / SAFE ENVIRONMENT

**1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.**

Interviews revealed that the safety and security of the residents is considered one of the most important goals of the facility. As a result there are a number of safety and security measures in place. Staff are instructed to be vigilant for any potential safety and security risks. The staff completes a daily checklist of the residential units. This checklist was described as a working tool between the staff and members of buildings and grounds personnel. In addition, buildings and grounds personnel conduct routine inspections in all of the buildings. Information from both of these sources is communicated to management. Work orders are prioritized according to the level of risk involved with critical issues addressed immediately.

Seven of those interviewed identified the safety alerts prepared and forwarded to staff by the facility risk manager as an example of the how serious the facility is about addressing safety concerns. For example, when it was noted that there was an increase in the number of falls within the facility, the risk manager prepared a safety alert regarding ways the staff could prevent falls both for the residents and for themselves. Several of the safety alert sheets were observed on the units toured.

The facility conducts routine fire and medical emergency drills. Fire drills are conducted monthly so that one is completed on each shift quarterly. Residents are evacuated during the drills so that the facility has an accurate assessment of the time it would take to successfully vacate the buildings.

NVTC has five safety and security officers who provide around the clock security services on campus. The majority of people serving in this department have experience in either law enforcement or security work. Two of the officers were newly hired and in training during the inspection process but were scheduled to begin their regular duties within several weeks. The officers patrol the campus and conduct security checks of the buildings particularly during the evening and nighttime shifts. The officers escort fire department and emergency personnel to the proper locations on campus when incidents occur.

**2. There are adequate safeguards to protect residents from abuse and neglect.**

Interviews revealed that the facility has adequate safeguards established to protect residents from abuse and neglect. Protection of the residents begins at the hiring process with the initiation of background checks. Interviews revealed that even though staff may begin their employment prior to the facility receiving the information from the background checks, they are not authorized to provide sole supervision of a resident until the information has been received. Staff training regarding human rights and the procedures for reporting abuse and neglect occurs during pre-service training. Interviews

revealed that staff are provided with case scenarios for discussion to assure that they are able to apply the principles and procedures they are learning. Annual re-training for both human rights and reporting abuse and neglect is required.

Interviews indicated that unit management conducts regular walkthroughs of the units across all shifts, which serves as a safeguard against abuse and neglect. Another mechanism identified was the event reporting system, which allows for an administrative review of an incident that is unexplained or suspicious without a specific allegation. Interviews with administrative staff indicated that the risk manager reviews each incident and will refer cases to the abuse investigator for review if there are any questions regarding the circumstances surrounding an event. The facility has a system for electronically reviewing incidents and responding to questions in a relatively short period of time.

There were 8 allegations of abuse and neglect made at this facility during the first six months of 2004, of which 5 were substantiated.

**3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.**

The risk manager tracks critical incidents. There were 14 critical incidents reported to VOPA and the OIG during the first six months of 2004. There were also 45 incidents of peer-to-peer aggression reported at the facility during the same time period. Thirty-seven of the incidents resulted in a minor injury to at least one of the residents involved.

All of the critical incidents, incidents of falls and incidents of peer-to-peer aggression are reviewed by the senior management team. The risk manger looks for trends in the data by conducting routine reviews to determine not only what events are occurring but also when and where the events take place. His information has been used in the past to effect changes in unit management, such as determining times when increased supervision of the residents is appropriate.

The risk management and residents' safety committees also review the aggregate data during their regularly scheduled meetings. When concerns are identified, plans of action are developed and followed until resolved.

Interviews with medical and nursing personnel revealed that the facility's on-going and routine review of the residents' healthcare status is an additional safeguard for protecting the residents from critical and/or life threatening events. The facility completes many preventative health checks on the residents. It was also noted that staff, in general, serve to protect the residents from life threatening incidents.

**4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.**

Interviews with 7 administrative, clinical and direct care staff, and a review of 3 records with behavioral plans, the behavioral treatment policies and procedures for psychological services, the restrictive procedures policy (NVTC Instruction 5300) and the policy on the use of protective restraints (NVTC Instruction 5301) demonstrated that the facility implements restrictive procedures in accordance with the facility policies.

As with the other facilities in the state system, staff are trained in the Therapeutic Options for Virginia (TOVA) model which focuses on developing effective working relationships. It also provides staff with a greater understanding of how to effectively apply behavioral management strategies. The facility has six psychologists and six assistants. Psychological services also reported having 5 interns at the time of the inspection. The psychologists are responsible for completing functional evaluations of problem behavior(s) and developing programs that can actually be carried out by staff. They also provide a lot of training for direct care staff. The facility data indicated that there are 86 residents with behavioral management plans, but 80 of these programs are behaviorally non-restrictive. The facility data also indicated that there are 59 residents with protective restraints. Among the types of protective restraints used are seatbelts, helmets, mitts and shower chairs. Interviews revealed that there is one resident with an approved physical restraint program. The team was also informed that there is one resident at the facility who has isolated time-out as an approved intervention in the behavioral plan. Isolated timeout is defined as "the removal of a client from ongoing reinforcement to a specifically designated time-out room". NVTC complies with the CMS regulations, which outlines the circumstances under which ICF/MR facilities can use the time-out room. These include:

- The use of the time-out room has to be a part of an approved systemic time-out program.
- The use of the time-out room can not be used as an emergency intervention,
- The client is under direct constant visual supervision while in the time-out room
- The door to the time out room is held shut by staff or by a mechanism requiring pressure from staff

**5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.**

Human Rights training is provided for all staff at the time of orientation and annually thereafter. Residents and their legally authorized representatives are advised of the human rights process at the time of admission and at least annually. Documentation of this is located in the resident's record.

The facility has both an informal and formal process for handling complaints. The facility director handles informal complaints, as is the procedure with the other training

centers. It was reported that the facility handled 1 informal complaint during the first six months of 2004. There were no formal complaints during the same time period.

Documentation of notification regarding resident's rights and the complaint process was located in the resident records that were reviewed.

**6. Medication usage is appropriately managed.**

Interviews revealed that medication administration and review is under the purview of the pharmacy at NVTC. The facility has 44 trained medication assistants whose primary responsibility is to administer medications. The team was informed that nursing personnel provide supervision to the process and conduct random checks to assure that the medication assistants are properly performing their duties. Nursing staff also conducts refresher courses quarterly addressing the proper storage and administration of medication as well as procedures for documentation of medication usage. It was explained that the registered nurses (RN) have a very good working relationship with the medication assistants and as such, the assistants do not hesitate to call if they have questions regarding a medication. Medication errors are reported and tracked both by the Director of Nursing and the Pharmacy and Therapeutics Committee.

**7. There are mechanisms to address areas of concern regarding staff safety.**

Interviews with administrative staff indicated that the facility does have a mechanism for addressing staff safety. There is an expectation at the facility that staff injuries are to be reported in a timely manner. The Human Resources Office tracks staff injuries and workmen's compensation claims are filed, as appropriate.

The Safety Committee addresses workplace safety. Issues addressed by this committee include staff injuries, the maintenance and safety of equipment used by staff in executing their duties, and campus-wide security. The facility risk manager also tracks staff injuries. Safety alerts are forwarded to all the units to increase staff awareness regarding a potential area of risk. For example, an alert that outlined ways for staff to prevent back injuries was forwarded for review by all staff. The training officer is informed of any trends regarding staff injuries so that additional training can be provided, such as proper body mechanics in order to avoid injuries during lifts. Environmental safety checks identify and correct physical conditions that would have an impact on the safety of both the staff and consumers.

## FACILITY OPERATIONS / LIVING ENVIRONMENT

**1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.**

Building 8 was extensively decorated for Halloween. Staff explained that Halloween rivaled Christmas at the facility for being the most enjoyed event. It was reported that the facility was having a hayride and a costume dance over the Halloween weekend.

There were more personal items observed in the units in Building 8 than in Building 6. It was explained that Building 6 was designated for those individuals with more challenging behaviors. The behaviors exhibited often limited the type and number of items placed on the walls as a safety precaution. Curtains or other window coverings were used to afford the residents privacy.

**2. The residential environment is clean, odor free and well maintained.**

Members of the OIG team conducted tours of selected residential units on campus, including Building 6 Units A and C, and Building 8 Units A and C. These buildings were noted to be clean, well maintained and odor-free. Furniture in the living areas appeared comfortable and well maintained. No broken or torn areas in the fabric were noted. Efforts at making the units comfortable and home-like were noted. Bedrooms were generally neat and clean. The overall campus is very well maintained. The grounds had been recently mowed. Pathways were well lit and free of hazardous conditions.

Administrative staff were asked to identify three of the most critical capital improvement projects that need to be addressed at the facility. Their response included:

- The renovation of the residential buildings in order to better serve the current population (estimated cost: $12.8 million)
- Renovations and addition to Building 4 and renovations to Building 1 (estimated cost: $5.6 million)
- Renovations to the food services operations (estimated cost: $2 million)

The following capital improvement projects were identified as active projects:

- Building 12 asbestos and mold abatement
- A fire alarm project in all of the buildings

Physical plant concerns that were identified as needing to be addressed were:

- A thermal ice storage unit is off-line which results in increased energy costs for the facility.
- A walk-in freezer has ice on the floor creating a safety hazard.
- The perimeter road and parking areas need resurfacing.
- Building 4 roof leaks and needs replacing.
- The Human Resources Office floods when the facility has a heavy rain.

**3. There is evidence that the residents are being taken care of by the facility.**

Throughout the tours, the team had an opportunity to observe the residents. All appeared properly clothed, clean and well provided for by the facility. The staff was observed treating the residents with dignity and respect. The manner in which staff interacted with the residents was supportive, friendly and professional. The residents observed seemed content.

**4. The facility provides for access to primary health care that is coordinated and comprehensive**.

On the day of the inspection, there were 187 residents. NVTC has three full-time physicians, including the medical director and a part-time psychiatrist. There are 20 RNs on staff, including the director of nursing, and 6 licensed practical nurses. Each resident receives an annual physical. A primary nurse is assigned to each living area. The nurse is responsible for managing the healthcare of the residents on the unit. Nurses are responsible for documenting the resident's healthcare status as needed but not less often than monthly. Plans of care are developed for any healthcare issue that surfaces. These are maintained in the resident's treatment/habilitation plan until resolved. The facility operates an infirmary that serves residents with medical conditions that require closer monitoring. The facility has an on-call system for addressing medical concerns after 5:00 pm. Nursing personnel indicated that there is an excellent on-call physician response time to the calls, usually less than five minutes

**5. The facility has a mechanism for accountability of resident's money.**

Interviews with staff indicated that the facility has an established procedure for the accountability of resident's money. Staff members who assist the residents in making the necessary purchases are required to submit a receipt.

## FACILITY OPERATIONS / STAFFING PATTERNS

**1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.**

Interviews were conducted with administrative and direct care staff. All those interviewed related that the facility maintains a sufficiently qualified staff to address the supervision and training needs of the residents, even though it was reported that the facility has a fairly high turnover rate for direct care staff. Staffing patterns are maintained through the use of overtime and part-time staff. Through recent exit interviews the facility has learned that the primary reason staff gives for leaving their positions is a conflict with his/her immediate supervisor.

In order to assure adequate staffing, the facility has initiated several recruitment and retention efforts including partnering with the Fairfax County Workforce Investment Board. All of the staff interviewed, whether administrative, clinical or direct care personnel, conveyed a belief that the average salary for the direct care staff needs to be increased. All of the direct care staff interviewed indicated that they have two jobs in order to make ends meet. NVTC has a more extensive pool of professional staff than the other training centers, including psychologists, occupational therapists and speech therapists.

Staffing patterns in the residential areas included the following:

- In Building 8A, there were 6 staff members for 19 residents.

- In Building 8C, there were 6 staff and 1 supervisor present for 18 residents
- In Building 6A and C, there were 15 residents and 8 staff present.

**2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of resident supports and care.**

Interviews indicated that the turnover rate for direct care staff positions in the facility is relatively high. At the time of the inspection, the OIG was informed that there were 28 vacant positions in direct care, which was reported as unusually high for the facility. This included medication assistant positions, shift supervisors and unit team leaders. The tenure of direct care staff was reported as being much shorter than staff in clinical, administrative and supervisory positions, many of whom have been at the facility for close to 30 years.

Staff interviewed related that overtime usage at the facility continues to be a concern. To address this issue, management has provided staff with several forums at which the problem and potential solutions have been discussed. Those interviewed indicated that one of the contributing factors to the use of overtime is the Virginia Disability and Sickness Program, which enable persons on probation to go out on short-term disability.

Several of the direct care staff reported dissatisfaction with the on-call system established to assure coverage. Reportedly, a staff member is scheduled for being on-call during one of their scheduled days off on a rotating basis. The person is required to call their unit one hour prior to the beginning of the shift to determine whether they are needed for coverage. If needed, they are required to come to the facility to provide coverage.

**3. Direct care staff possesses the competencies necessary for providing services.**

Interviews with training and supervisory staff, as well as a review of the training materials revealed that the majority of critical tasks for direct care staff are based on competency reviews, which involved either tests or demonstrations. Interviews revealed that by the time staff get to their assigned units, they have the baseline skills necessary for effectively completing their duties. Staff have the ability to participate in a number of training opportunities, both for professional growth and for advancement opportunities.

## FACILITY OPERATIONS / SYSTEM PERFORMANCE

**1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.**

Data collection is used to support and enhance facility performance in a number of areas. Staff training data is maintained to assure that staff have completed the training necessary to fulfill their duties. The Human Resource Office tracks the use of overtime and information obtained during the exit interview process.

Data collection is central to the work of both the quality assurance office and risk management at the facility. Both review critical indicators regarding the safety and treatment needs of the residents. This information is routinely used to develop performance improvement initiatives.

Other examples of data tracking within the facility include, but are not limited to: psychology staff use data to track the behaviors for which plans have been developed to determine the efficacy of the plans; pharmacy tracks medication use and errors; and medical staff monitors poly-pharmacy usage.

**2. There is a system for continuous quality improvement.**

Interviews with administrative staff and a review of the facility's quality management plan revealed that NVTC has a system for continuous quality improvement. The facility has initiated a number of successful quality improvement projects. Several of the initiatives discussed include the mentoring project; increased communications among staff through town meetings; and the 5A Catch a Rising Star Program. The latter is a program that recognizes employees whose actions, ideas or job performance supports the theme of working collaboratively and efficiently while keeping residents' needs always a focus and priority.

**3. Consumers and other stakeholders have an active role in program development, and quality improvement activities.**

Interviews revealed that families have not been formally involved in program development and quality improvement activities within the facility but that it is the philosophy of the facility to "give all a voice". It was reported that there was a large and active parents organization that is informally involved in the development and maintenance of quality services within the facility.

## COMMUNITY RELATIONSHIPS

**1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in its catchment area.**

The facility is engaged in a number of activities that are designed to develop and maintain working relationships with community providers and other agencies. NVTC has a well-established Regional Community Support Clinic, which provides specialized medical, behavioral, dental and respite services to members of the community with mental retardation. The facility provides its expertise to serve consumers in the community in an effort to help them remain independent and not have need of facility services. The facility director has been actively involved in the regional planning partnership, which has been meeting to define the needs of the region.

Staff are engaged with members of the community during times of transition such as admissions and discharge. There are multiple opportunities for staff to interact with their community counterparts during these processes.

**2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders:**

**a. With Community Services Boards**
Even though no formalized surveys have been conducted with the community services boards, there are many formal and informal mechanisms for obtaining feedback from the community.

**b. With parents and/or legally authorized representatives**
The facility has conducted surveys with family members and residents' legally authorized representatives.

**c. With the DMHMRSAS Central Office**
It was reported that there is not a formal mechanism for obtaining feedback from Central Office management regarding the facility's performance. Staff described several ways in which the facility is able to interface with the Central Office. These include the facility directors meetings, the medical directors meetings, and involvement with the Office of Risk Management. It was reported that the Commissioner has communicated his vision and goals for the system. It was also reported that the Office of Mental Retardation Services has been helpful.

Those interviewed indicated that the facility would appreciate more feedback from Central Office staff particularly regarding the data and other information that is routinely requested and provided.

**3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.**

Twelve staff members were asked about these quality statements, including administrative, clinical and direct care staff. Those interviewed indicated that the facility has provided a vital service to the community since opening its door through the provision of comprehensive residential, training and healthcare services to persons with mental retardation. In addition, staff spoke of the regional community support clinic as an excellent program, which enables the facility to share its expertise with the community. Staff at NVTC voiced a belief that the facility is working in partnership with community providers to address the challenging and changing needs of this special population. Both management and staff had a working understanding about the capacity of the community to provide services to persons that have both challenging behavioral and medical problems.

**4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.**

Interviews revealed that NVTC makes every effort to provide respite services when requested. Respite care is designed as a program of temporary care, 21 days or less, that is needed because of a "medical or other urgent conditions of the person(s) providing care or as a means of providing the care takers with a needed break". There were 35 requests for respite care during the period of July 1, 2003 and July 1, 2004. Four were denied. Two people were accepted but did not use the service. Twelve persons were accommodated through the 29 respite visits that were completed.